University of Alberta

What Highly Self-Critical Clients Experience During Therapy

By

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A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy
in
Counselling Psychology

Department of Educational Psychology

Edmonton, Alberta
Fall, 2007

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Your file Votre référence
ISBN: 978-0-494-32985-6
Our file Notre référence
ISBN: 978-0-494-32985-6

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ABSTRACT

Research suggests a strong link between the personality trait of self-criticism and the development of depression in individuals. Self-criticism is thought to develop in infancy and childhood in response to specific parenting and attachment experiences. Highly self-critical people experience more negative emotions and fewer positive ones than people who are not highly self-critical. They engage in ongoing, harsh, punitive self-evaluation and self-scrutiny, fear the loss of approval of others, and tend to have little faith in their social support systems. People who are very self-critical frequently have problems with interpersonal relationships. They may seek psychotherapy because they are experiencing depression or due to interpersonal problems they are having. Self-Critical individuals tend to benefit less from therapy than other clients, although the reasons why are not entirely clear. The purpose of this research has been to uncover some of the self-critical processes that may be occurring in therapy, that are preventing clients from obtaining greater benefits from psychotherapy. The research involved the use of semi-structured interviews and Interpersonal Process Recall (IPR) with eight psychotherapy clients. Data analysis of the findings indicate that self-critical processes such as ongoing, internal evaluation and self-criticism, expectations of judgment and rejection, anticipation of negative outcomes and events, as well as the tendency to keep some problems secret were occurring during the course of participants' therapy. Participants had often been in therapy prior to participating in this study, and the findings of the study suggest the need for

long-term treatment. The implications these findings may have for therapy, as well as recommendations for working with self-critical clients, are discussed. Further research is needed to confirm and extend these findings.

Dedication

This Dissertation is dedicated to my father, George Janzen, whose namesake I am, and whose tragic death kept him from being here to see me finish.

Acknowledgements

My Participants

Thank you for giving me the precious gift of your participation. I could not have done this without you. What you did took extraordinary courage and a willingness to act for the greater good.

My Supervisor

Bill, your support and guidance from the very beginning of this process right to the end has been invaluable. From those inchoate discussions of possible research topics through incomprehensible and unusable interviews to analysis and writing, you've provided encouragement, direction and the occasional kick-in-the-pants I needed to keep going.

My Committee

Thank you for your feedback and guidance throughout this process. Your kind, generous and encouraging words helped bolster my faith in my work and my document. Your gentle approach made the process so much more enjoyable.

My Family

Mom, Ramona, Rita, Joyce and Kerri,
I can't imagine how I could have gotten through some of the dark days of analyzing and writing without your support, cheerleading, encouragement, faith in me, and prayers. Much of the credit for finishing goes to you!

My Friends

Where do I start? Deb, Doug and Pat, as usual, you've been with me through thick and thin. Shelly, Carley and Andrew, thanks for all the times we 'talked dissertation.' Your work on your own dissertations inspired me. To the BrunchRunners, what would I have done without you guys keeping balance in my life, promoting my mental health, encouraging both my running and my schoolwork? I feel I can't name all the friends and colleagues along the way who have encouraged and supported me.

Special Mention

Dr. Janzen, although you have had little to do directly with my dissertation, I feel I owe you a debt of gratitude for supporting me academically and professionally. My first opportunities to work as a Provisional Psychologist came from you. I enjoyed my years and various roles at the Clinic and feel a sense of pride being able to say you have supervised me.

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CHAPTER ONE
INTRODUCTION

When Depression Resides Next Door – A personal vignette

The word "epidemic" is defined as "an outbreak of a disease that spreads more quickly and more extensively among a group of people than would normally be expected" (Encarta Dictionary, 2007). Depression could easily be called a problem that is quickly reaching epidemic proportions. It is one of the most rapidly growing mental health problems facing the world today. Räty, Ikonen and Honkalampi (2006) wrote "Major depression is such a prevalent illness worldwide that practically everyone has either direct or indirect experience of it." Whether the experience is direct or indirect, an individual is unlikely to forget what depression is like. As a student, therapist, sister and neighbour, I have come in contact with depression. Before I begin describing the rationale, methods and results of this research, I would like to share one of those personal experiences.

In the late 1990's, I lived next door to a woman named "Anneke."[1] Anneke was a "fifty-something" woman with short, dark, thick curly hair and black eyes. Some days, her eyes seemed to shine like brightly polished Alaskan black diamonds. She had an average build with a sense of a strong body. You had no trouble imagining her hauling buckets of fresh water or vigorously hoeing rows of garden vegetables. She just seemed strong, like she'd be a hard worker. Her hands reminded me of those beautifully sculpted "Praying Hands" so often seen in stores carrying religious merchandise. She was in many respects an ideal neighbour. She was tidy, lived quietly, and was friendly when you met her in the hall. Once in a while she dropped by to borrow something, maybe the traditional cup of sugar or something similar. She was more than willing to return the favor, too.

I can't remember how it came to be that she started to tell me more about herself. Perhaps when she found out what I was studying at school,

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[1] Her name and some other relevant details have been changed to protect her identity.

she felt she could confide in me. Maybe it was when she stopped by for that cup of sugar, that I asked how she was doing. Little by little, the curtain was drawn back to reveal a person who'd lived in the deepest, darkest pit of despair for more years than she could remember.

Anneke, I'm sure, appeared to most people who met her casually to be a happy, well-adjusted individual. She volunteered at a hospice, at the Symphony, and at numerous festivals in any given year. Her apartment balcony had well-tended flower boxes, and her kitchen window had distinctive lace curtains. Friends occasionally dropped by, and family – children and grandchildren – always kept in touch. Anneke had moved to Canada from overseas, I think, as a teen. She still had the slightest accent, although she spoke English very well. She seemed energetic. I often met her as she was hurrying down the street with an appointment to get to and a broad smile on her face.

Anneke told me she had left her abusive husband some years ago. She had been reluctant to get into a new relationship ever since. It did not sound as though it had been easy for her to make ends meet as a single mother with small children. She described long days with hard work, little sleep and few luxuries when she was raising her children. She once commented she had been depressed for 30 years. That always stuck in my mind. Sometimes, in my own dark moments, I feared that someday I would turn into her – a woman alone, depressed and struggling to create a meaningful life. She shared that she struggled daily with depression and frequently contemplated suicide. Always, what stopped her was her family – her children and grandchildren. She knew they would be devastated if she were to kill herself. But knowing that did little to ease her misery. On more than one occasion, she described how she longed to feel happy. She craved that more than anything, but there was nothing that seemed to give her happiness. At least nothing that gave her happiness that lasted for any length of time. Happiness seemed as fleeting an experience for her as the cocaine high is for a long-time user.

It was not that Anneke did not try to be happy and find meaning in her life. She sought it in her relationships with family and her few close friends, in her volunteer work, in her flower pots. Perhaps, her searches for meaning and purpose were too direct. She attended therapy, regularly saw a psychiatrist, and tried all sorts of anti-depressant medication. All to no avail. At one point, she was admitted to hospital for ECT. I remember afterward, her struggling to recall my name, knowing she should know it but not being able to find it in her memory. The depression abated somewhat after that, but it was a temporary fix. I do not think the improvements lasted even six months. It was heart-breaking to hear her describe her descent back into depression after that procedure.

In the Fall of 2001, I moved from that apartment building, and said good-bye to Anneke. She was cheerful and upbeat at that time. She had recently met a man and was very happy. A few weeks after my move, I received a card from her. She and her new friend were engaged to be married, I think. They were going to move in together. She said she was the happiest she had been in her whole life. Soon, the flower boxes disappeared from her balcony, the lace curtains from her window. I never heard from her again. I'd like to leave the reader with that happy-ever-after ending, but I have been past that balcony a number of times since moving, and I have seen her signature lace curtains back in the window. I hope it is just coincidence. I hope it is not her, and that she really has turned things around and been able to develop a more sustainable happiness, but I am really not sure.

Anneke's depression appeared to have some features suggesting a self-critical personality style. She was quite independent and somewhat socially isolated. She was quite critical of herself for not being happier when there were people suffering and in more physical pain than she was. Her volunteer job at the hospital reminded her of the contrast between her physical health and other people's physical suffering. She saw her depression as a failing, I think. If she could only find the right way, do the right things, focus on the positive in her life, relax, then she would not be so

depressed. Maybe if she found the right medication. But none of the medications worked. That was another way she seemed to feel she had failed. She seemed disappointed and frustrated that the efforts of her psychiatrist and psychologist had not met with more success. They could not seem to cure her depression. Perhaps it was not within their power to do so. If most depressed people tend to fall into one of two categories – self-critical or dependent – then she definitely seemed to fit into the former category much more than the latter.

I do not know if my research about therapy clients who are very self-critical would have had the potential to help Anneke at all. I remember how helpless I felt so often when we talked. There was little I could do to alleviate her sad feelings. It must have been hard for her family and friends to stand by and witness her struggles year after year after year. Perhaps it was that a depression so entrenched was unlikely to ever lessen, to ease or remit. I wished I could make a difference. Maybe I cannot make a difference for Anneke, but part of my motivation for conducting this research has been the hope and intention that in the future, I can make a difference for someone like her.

Introduction to the Problem

Some of us have been told on occasion that we are our own worst enemies and our own harshest critics. Comments about one's inner critic are almost as common in the coffee room as in the therapy room. The critical inner voice is identified both as the motivator to keep us striving for excellence and the roadblock that keeps us from moving ahead. There can be a helpful function to the "inner critic," just as Jiminy Cricket served a purpose for the errant Pinocchio. However, for some individuals, the critic that dwells inside is the creator and sustainer of a great deal of misery and hardship.

The relentless self-appraisal that is the background noise of the self-critic's life can lead to a rather miserable existence. Highly self-critical people often experience more negative affect than the average person and far less than their share of positive affect. They often are unable to enjoy

their accomplishments and successes, even though they may be quite capable individuals. Their interpersonal relationships are often distant and cold, in part because they fear intimacy, in part due to their often punitive, critical interactions with others. They do not seem to enjoy their relationships with others as much as people who are less self-critical. Depression is often the result of their intense, ongoing self-criticism. Even worse, the ensuing depression can serve to perpetuate the self-criticism that started it in the first place. A great many of the clients who seek psychotherapy are people "suffering" from the effects of excessive self-criticism. Yet all-too-often, they are not able to fully benefit from therapy. It was psychotherapy clients like these who were the focus of this research.

Background

A recent Statistics Canada survey (Statistics Canada, 2003) showed that symptoms of depression were as common among Canadians (4% of people surveyed) as such ailments as diabetes (5%), heart disease (5%), or thyroid conditions (6%). The authors reported that mental disorders (including depression) were the third highest source of direct health care costs in 1998, according to Health Canada estimates. These results are consistent with World Health Organization (WHO, 2007) estimates (see below), and highlight the vital need to find effective methods of treating mental disorders. The cost to the Canadian health care system is staggering: estimated to be nearly $5 billion in 1998. Additionally, there are costs in employee absenteeism, lost productivity as well as social and interpersonal costs. The survey also showed that those individuals who had experienced feelings and symptoms of the mental disorders or substance-use problems surveyed, were more likely than the general population to have had recent physical ailments.

This trend of increasing rates of depression is not only present in Canada, but occurring around the world, especially in Western and developed nations. According to recent information from the World Health Organization (WHO, 2007; Yapko, 2006), depression is the number one mental health problem world wide. It is the fourth most significant cause of

suffering and disability globally, after heart disease, cancer and traffic accidents. Rates of depression are expected to increase both within Canada (Statistics Canada, 2003) and world-wide (Brundtland, 2001). It is projected to be the second greatest cause of suffering worldwide by the year 2020 (Brundtland, 2001). Research has shown that self-criticism is one of the most frequent and important antecedents of depression.

Self-criticism or self-evaluation is both a process that everyone engages in and a personality trait. Some people exhibit higher levels of this personality trait than others. Having a highly self-critical personality can have many negative consequences. Much of the research on depression suggests that people who are highly self-critical often experience depression and may be much more prone than others to developing depression (see for example, Blatt, Zuroff, Bondi, Sanislow & Pilkonis, 1998; Blatt & Zuroff, 1992; Dunkley, Zuroff & Blankstein, 2003; Powers & Zuroff, 1988; Shahar, Blatt & Ford, 2003). Based on his review of a number of studies on depression, dependency and self-criticism, Shahar (2001) suggested that self-criticism emerged in the research as a "severe vulnerability factor" for depression.

Self-critical individuals also have a tendency to have difficult and troubled relationships with others (e.g., see Blatt, Hart, Quinlan, Leadbeater & Auerbach, 1993; Mongrain, 1998; Mongrain, Vettese, Shuster & Kendal, 1998; Thompson & Zuroff, 1998, 1999a, 1999b; Vettese & Mongrain, 2000; Zuroff & Duncan, 1999; Zuroff, Stotland, Sweetman, Craig & Koestner, 1995). Self-criticism impacts how people experience and shape their world (Santor & Zuroff, 1997, 1998). Some have wondered whether relationship problems create self-criticism and depression or vice versa. To some extent, they create and reinforce each other. There is evidence to suggest that in the case of highly self-critical, depressed individuals, relationship problems may occur as a result of the self-criticism (e.g., Mongrain, Vettese, Shuster & Kendall, 1998; Santor & Zuroff, 1997, 1998). Relationship problems may also contribute to the maintenance of self-critical thoughts and behaviour and to the development or maintenance of depression.

These interpersonal difficulties also extend to the process of therapy. While the depressive effects of self-criticism may bring people to therapy, the interpersonal effects of self-criticism may impede the development of a positive and helpful therapeutic relationship and appear to prevent individuals from benefiting as much as they could and need to from therapy (Blatt, 1999; Blatt, Quinlan, Pilkonis & Shea, 1995; Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004; Shahar, Blatt, Zuroff & Pilkonis, 2003; Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow & Simmens, 2000).

The relationship between therapist and client is one of the key ingredients in successful therapy (Ackerman & Hilsenroth, 2003; Beutler & Harwood, 2002; Horvath, 2001; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Howgego, Yellowlees, Owen, Meldrum & Dark, 2003; Joyce, Ogrodniczuk, Piper & McCallum, 2003; Lambert & Barley, 2001). This relationship is often negatively affected by the client's personality trait of self-criticism. Because of their self-criticism, some, but not all, clients are unable or less able to benefit from psychotherapy. For example, Dunkley, Zuroff and Blankstein (2003) found that clients who were highly self-critical benefited less from therapy overall than clients who were only minimally or moderately self-critical, particularly in the latter half of brief therapy (the study looked at therapy that was16 sessions long).

Self-criticism often impacts the process of therapy negatively. Until recently, very little was known about what highly self-critical clients are experiencing, thinking and feeling in therapy that either impedes or facilitates the therapeutic process. Previous research in this area has tended to rely on quantitative measures such as self-report questionnaires and scores/changes on such measures as the Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti & Quinlan, 1976) and the Working Alliance Inventory (Horvath & Greenberg, 1986, 1989). Few qualitative research studies on depression and self-criticism were found. In order to begin addressing this gap in the research, I conducted in-depth interviews with clients who were identified as being very self-critical. The psychotherapy

clients I involved in this research process were concurrently participating in psychotherapy.

In this document, the reader will be provided with a review of relevant literature – relating to both depression and self-criticism. This is necessary because the two are so often inextricably linked. The theoretical foundations, rationale and methods by which this research was conducted will be detailed. I will share my findings and discuss them in the contexts of therapy and research.

The Research Question:

What are the accounts that highly self-critical people share about their experiences in psychotherapy?

My research was exploratory in nature. I conducted semi-structured interviews, including a portion of videotape review of a therapy session. The goal was to learn from the client what s/he was thinking, feeling and experiencing in session, whether or how that might be related to her/his self-criticism (SC), and what effects her/his SC seemed to be having on the therapeutic relationship. The results would be a blend of participants' perspectives and my interpretations. My intention was to interview participants as close as possible to the time that they were engaged in the process of therapy. The use of a videotape review and conducting the interviews while participants were engaged in therapy served to provide a different kind of data than would have been obtained had I waited until participants were no longer involved in therapy and were not able to direct their comments towards a particular session vividly portrayed before them. It was hoped that using one particular session to view and discuss would illuminate a different aspect of SC than might have been obtained if the participants were interviewed after therapy had ended and were reflecting on their overall experiences.

CHAPTER TWO
LITERATURE REVIEW

In this literature review, I will cover a number of research domains relevant to the present research project. I will begin by giving an overview of depression and by discussing several different theoretical approaches to understanding and treating depression. This is necessary for three crucial reasons. Depression is a severely debilitating mental health condition that is occurring with alarming frequency in North America and the world over. Second, self-criticism has been shown to be a personality variable that leaves an individual highly vulnerable to developing depression. Third, highly self-critical individuals who are participating in psychotherapy have often been shown to often benefit less from their therapy than other, less self-critical people.

There will be a detailed discussion of Blatt's (2004; Blatt & Zuroff, 1992) conceptualization of the two basic personality processes, interpersonal relatedness and self-definition, and their link to depression. The particular effects of self-criticism (SC) on interpersonal relationships in general and on the therapeutic relationship and treatment outcomes will be outlined. The therapeutic alliance has been found to be one of the best predictors of therapy outcome. It is important to understand the therapeutic alliance in order to better understand the negative effects SC has on it. Therefore, I will also include a discussion of the history of the research relating to the therapeutic or working alliance, as well as describing the elements of the working alliance and the impact of SC on it.

Depression

Epidemiology

As indicated in the introduction, depression is one of the most significant causes of human suffering both within Canada and across the world (Brundtland, 2001; Manderscheid, 2006; Solomon, 2006; Statistics Canada, 2003). Discussing the situation in the United States, Solomon (2006) recently wrote, "It costs more in treatment and lost productivity than

anything but heart disease" (p. A31). The World Health Organization (WHO, 2007) recently identified depression as the "leading cause of disability..." affecting "about 121 million people worldwide." (WHO, 2007). Depression has been researched among such diverse groups as elderly individuals in rural China (Chen, Wei, Hu, Qin, Copeland & Hemingway, 2005), people living in four (4) cities in Mexico (Slone, Norris, Murphy, Baker, Perilla, Diaz, Rodriguez & Rodriguez, 2006), Australian (Sawyer, Miller-Lewis & Clark, 2007), Canadian (Nguyen, Fournier, Bergeron, Roberge & Barrette, 2005) and British (Anonymous, InPharma Weekly, 2005) youth, and Finnish patients (Poutanen, Mattila, Seppälä, Groth, Koivisto & Salokangas, 2007).

A survey of nearly 27, 000 respondents in the United States (Wu & Anthony, 2000) estimated that two in 100 adult females and one in 100 adult males experienced an episode of depressed mood lasting at least two weeks[2]. For many, this is not the first time they have experienced such a mood. As noted in the Introduction, Canadian rates are quite similar. Four percent of individuals questioned by Statistics Canada (2003) in a Community Health survey reported showing symptoms commonly associated with depression. Criteria from the DSM-IV (American Psychiatric Association, 2000) were used to assess the presence of depressive symptoms in surveyed individuals.

There are gender differences in rates of depression (Kuehner, 2003). The rate of depression in Wu and Anthony's (2000) survey was nearly twice as high for women as men, 1.9% and 1% respectively. Among women, the prevalence rates of depression decline during the adult years until the age of 60, after which there is another peak. This rate differs from men, whose rates of depression steadily decline throughout adulthood. Married women were about 50% more likely to be depressed than married men. Wu and Anthony (2000) further found that prevalence rates of depression were not affected by demographic factors such as race/ethnicity, marital status, employment status, geographic location and urbanicity. They noted, "being

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[2] From the authors' description, it seems that during any given span of about two weeks, approximately 1% of men and 2% of women will experience a spell of depressed mood.

female, having less than 12 years of education, and being age 44 years and younger were observed to be associated with excess prevalence of depressed mood" (p. 163-164), even when adjustments were made for the type of neighbourhood people lived in. Gender differences in levels of depressive symptoms have been detected in adolescence (Galambos, Leadbeater & Barker, 2004; Shahar, Blatt, Zuroff, Kuperminc & Leadbeater, 2004), "with girls being more affected than boys" (Galambos, et al p. 16).

What is also alarming is that not only are so many people suffering from depression, but so few are receiving help or treatment. In the Canadian Community Health Survey (Statistics Canada, 2003), less than one-third of those surveyed saw or talked to a health professional within the twelve months prior to the survey regarding their mental health or substance dependency issues. People were most likely to consult their family physician. Almost 12% consulted a psychiatrist, and over 8% consulted a psychologist. Many people who could benefit from support regarding mental health problems are not presently receiving those services. The bright spot in all of this was how people who received treatment felt about it. Of those surveyed who had accessed help, 60% indicated their professional consultations had been "a lot helpful." Most reported being satisfied or very satisfied with the treatment and services they received.

Symptoms and Diagnosis

Depression has been characterized a number of different ways by theorists, researchers and practitioners, depending upon their focus. The authors of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000), one of North America's most widely used sourcebooks in diagnosing depression, have chosen an atheoretical stance. They have focused on the symptoms associated with depression.

According to the DSM-IV (APA, 2000), a major depressive episode is a period of at least two weeks that is characterized by a depressed, sad or irritable mood, the experience of anhedonia, changes in appetite, activity levels and sleep patterns, difficulties thinking, concentrating or making

decisions, feelings of worthlessness or guilt, and/or recurrent thoughts about death or suicide. These may be accompanied by social withdrawal, tearfulness, brooding, obsessive rumination, or complaints of physical pain. In this approach, depression is seen as occurring on a continuum, ranging from transient mild dysphoria to severe long-term depression. That is, it is believed that there is only one type of depression, with different individuals experiencing it to different degrees.

Consistent with the information from other sources in Canada (Statistics Canada, 2003) and the U.S. (Wu & Anthony, 2000), the DSM-IV (APA, 2000) reported that women appear to be at substantially higher risk of developing depression than men. The increased risk appears in adolescence and continues throughout the lifespan. Most individuals who experience a depressive episode will eventually return to normal functioning and have a remission in symptoms. However, in approximately 20 – 30% of cases, the symptoms persist for months or even years, and result in considerable distress and disability for the person.

Principal Models and Treatments of Depression

Models of Depression.

Many different theories have been developed to attempt to explain the causes of depression. There are three basic approaches to explaining depression into which most theories can be placed. First, there are biological explanations. Second, there are cognitive and cognitive-behavioural models of depression. Third, there are social and interpersonal models of depression. Proponents of biological models usually favor a biological, pharmacological solution (e.g., antidepressant medications). Proponents of cognitive and interpersonal models of depression usually advocate for the use of some type of "talk therapy," alone or in combination with medication.

Biological Causes. Depression is hypothesized to be caused by some biological, physiological factor. For example, research has shown that depression tends to occur more frequently among the blood relatives of a depressed person than among unrelated individuals raised in the same

environment (Bower, 2005; Hong & Tsai, 2003; Lieb, Isensee, Höfler & Wittchen, 2002; Rice, Harold & Thapar, 2005; Stephenson, 2003). Thus it is theorized that a genetic vulnerability to or predisposition for depression increases the likelihood of developing the disorder.

Another biological approach to depression has theorized that chemical imbalances within the brain, or the incorrect chemical response of neural transmitters causes the depression (e.g., see Kobayashi & Suzuki, 2007; McEwen, 2003; Meyer, 2007). It is thought that genetic and environmental causes may be working alone or in conjunction to create the depression. When biological factors are presumed to have caused the individual's depression, treatment is often pharmacological – i.e., medication is used that is believed to correct the chemical imbalances in the brain, or to facilitate optimal neurotransmitter action.

A variety of antidepressant medication is available for treating depression (see, for example, Guaiana, Barbui & Hotopf, 2003; Murrin, Sanders & Bylund, 2007; Nasr & Wendt, 2006; Ravindran & Kennedy, 2007). Side effects of medication can be a concern, although some of the newer antidepressants are reported to have fewer side-effects than more traditional ones. None-the-less, medication continues to be recognized as both effective and paradoxically controversial. In 2005, Moncrieff and Kirsch wrote,

> Although many trials do find antidepressants are superior to placebo, many do not, including some of the largest and most well known landmark trials such as the Medical Research Council trial and the early National Institute for Mental Health trial. (p. 156).

There is growing recognition that antidepressant drug trials that show negative outcomes tend not to get published (Moncrieff & Kirsch, 2005). A growing number of published studies have begun refuting the effectiveness of antidepressants. Dr. David Burns (2006) argues that the research simply does not support one of the fundamental arguments for the use of at least one type of antidepressant, selective serotonin reuptake inhibitors (SSRIs).

Research that he participated in during the 1970's simply did not support the hypothesis that depression results from a serotonin deficiency in the brain. He asserted, "In fact, the latest studies raise serious questions about whether these new antidepressants have *any* true antidepressant effects at all, above and beyond their placebo effects" (Burns, 2006, p. 50, italics in original). He goes on to note that use of SSRIs have been linked to increases in suicide rates. Burns and others (e.g., Yapko, 2006) assert that antidepressants pose many more risks and hazards (e.g., negative side effects) than benefits and that decisions to promote their use are driven by their profit potential more than their actual efficacy. By contrast, Burns wrote, "Hope is the most potent antidepressant in existence" (p. 54).

A recent Consumer Reports (2004) survey found that drug therapy relieved symptoms faster than talk therapy. Respondents indicated a much higher rate of side effects from medications that those reported by manufacturers. It often took two or more trials before an effective medication was found. Furthermore, relapse rates (becoming depressed again) for medications have consistently been found to be higher than for talk therapy (Consumer Reports, 2004).

Cognitive Models. The second model of causes of depression hypothesizes that depression occurs due to faulty cognitions on the part of the individual. One highly regarded proponent of such an explanation is Aaron T. Beck, and his model of depression will be discussed in more detail below. The faulty cognitions that cause depression are/were believed to be unduly negative interpretations of events and interpersonal interactions. Abramson (e.g., Abramson, Dykman & Needles, 1991; Abramson, Metalsky & Alloy, 1989; Gibb, Abramson & Alloy, 2004) developed 'Attribution Theory' to explain the causes people attribute for events, feelings and experiences in their lives.

Briefly, "attribution style" is a term that refers to the causes an individual identifies for the occurrence of various events in her/his life (Yapko, 2003, personal communication; see also DeRubeis & Hollon, 1995; Nolen-Hoeksema & Girgus, 1995; Robins & Hayes, 1995 and Abramson, Alloy

& Metalsky, 1995 on 'explanatory style' and depression). Attribution style derives in part from the hopelessness theory of depression (see Abramsom, Metalsky & Alloy, 1989). Attribution styles are theorized to occur along three main dimensional axes. They can be stable or unstable, internal or external, and global or specific. A stable attribution style is one in which the individual believes that an event is due to factors that are unlikely to change. An internal attribution style is one where an event is seen to be caused by factors within the person, whereas an external style is one where causes for events are seen as existing outside of the individual and his/her capabilities. If an event is attributed to global causes, these causes are thought to affect the person across situations, while specific attributions link an event to a particular situation or context. It is thought that attributing the causes for positive events and feelings to external, specific and unstable reasons and attributing negative events and feelings to internal, global and stable factors would contribute to the development of depression. Highly self-critical depressed people are thought to be more likely to attribute negative events/experiences to stable, internal and global causes.

When the causes of depression are believed to be faulty cognitions, treatment efforts focus on changing the way people think and the way they process relationship information. Cognitive-behavioural therapy is one widely used "talk therapy" approach that is used to treat depression. For instance, Burns (1999) recommends identifying "automatic thoughts" and "distortions" and coming up with "rational responses" in order to change one's feelings. He further provides strategies to conquer depression by changing thinking patterns such as "jumping to conclusions" and "fortune-telling." For many individuals, these kinds of strategies have been invaluable in helping change both their mood and their expectations about interpersonal events.

Social/Interpersonal Models. The third model of the causes of depression is based more on social and interpersonal factors and relationships. (Coyne & Thompson, 2003; Coyne & Whiffen, 1995; Downey & Coyne, 1990, Harris & Brown, 1978 – cited in Joiner, Coyne & Blalock, 1999).

Depression is believed to occur as a result of the relationships and social interactions an individual has. For example, Harris and Brown (1978) conducted a seminal research study and found that "severe life events, often involving loss and disappointments in close relationships, had a key role in precipitating depression" (Joiner, Coyne & Blalock, 1999, p. 6). Social isolation or the lack of an intimate relationship with someone to confide in was found to be a crucial factor that led to individuals becoming vulnerable to developing depression.

Blatt's (2004; Blatt & Zuroff, 1992) model of depression, which will be discussed in detail below, and which this research focuses on, is also based on environmental, social and interpersonal causes of depression. Blatt's model begins with early infant and childhood experiences, which in turn create and influence interaction patterns as well as emotional responses.

When the causes of depression are believed to be interpersonal in nature, treatments preferred tend to be psychodynamic therapy or process-experiential and similar types of psychotherapy.

Briefly, psychodynamic therapy might be thought of as the original form of psychotherapy. "Psychodynamic models take as their starting point the proposition that we have an 'inner world' that has a powerful influence on how we think, feel and behave" (Howard, 2006, p. 9). It is believed that this inner world is largely unconscious, and mostly inaccessible to the individual. A central tenet of psychodynamic psychotherapy is that people develop defenses in order to cope with the challenges of life. An example of a defense mechanism is projection, "the means by which we attribute to other people characteristics in ourselves that are unacceptable to us" (Howard, 2006, p. 19). Defenses are not thought to be inherently problematic, but can become so when rigidly used.

In psychodynamic therapy, interventions focus on providing interpretations to clients and working through transference issues (Howard, 2006; Ursano, Sonnenberg & Lazar, 2004). Transference occurs when clients 'transfer' onto their therapists their expectations of how the relationship will unfold. It is believed that early childhood experiences create a template

guiding our expectations and interactions in relationships. Clients use this template to interact with therapists. A psychodynamic therapist will bring to her client's attention when he is transferring this template onto their relationship, rather than responding to the real interactions as they are happening. Countertransference issues occur when the therapist projects her relationship template onto the therapeutic relationship, in a manner similar to the client.

Process-experiential therapy differs somewhat from both cognitive (or cognitive-behavioural) therapy and psychodynamic approaches. Gaining insight into one's problems, thoughts and actions is considered helpful but not the primary focus of therapy. Clients are encouraged to identify and experience their emotions. Interventions such as role-plays and "empty chair" techniques may be employed to facilitate new experiences of familiar situations, and to provide practice for different ways of interacting with others. It is believed that if emotions are not expressed in a healthy manner, they will be expressed indirectly and in negative and potentially damaging ways.

Obviously, the above is not an indepth exploration of biologically based, cognitive or interpersonal treatments of depression. Such an endeavor is beyond the scope of this review. However, it is intended to provide the reader with a brief overview of the different ways depression is believed to be caused, along with the typical corresponding treatment approaches.

According to Lambert and Bergin (1994), studies have shown that psychotherapy is as effective as, or more effective than, pharmacotherapy in some instances, in the treatment of depression. In her report on the findings of the National Institute of Mental Health (NIMH) – Treatment of Depression Collaborative Research Project (TDCRP), Elkin (1994) stated that interpersonal therapy[3] and cognitive-behavioural therapy are as effective

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[3] Interpersonal Therapy (IPT) begins with a basic assumption that psychological problems develop within an interpersonal context. Interventions are directed toward changing the person within her/his interpersonal context and thus reducing psychological problems (Levenson, Butler & Beitman, 1997).

as pharmacotherapy and clinical management in reducing depressive symptoms and improving functioning. A more recent study (see Hollon et al, 2005) found that Cognitive Therapy is more effective than drug treatment in reducing the likelihood of a relapse of depression. Similar conclusions have been drawn in other research (see also Teasdale, et al, 2000), including in the Consumer Reports (2004) survey mentioned above, where the most effective treatment for depression was a combination of drugs and talk therapy. Drugs were found to be more effective for short-term relief, talk therapy (especially greater than 12 sessions) was most effective in creating lasting positive changes.

Psychiatric or psychological help is often of significant benefit for individuals suffering from depression (Watson, Gordon, Stermac, Kalogerakos & Steckley, 2003). A recent Consumer Reports (2004) survey suggested that psychiatrists, psychologists and social workers were equally effective as therapists. How effective psychotherapy is found to be in the treatment of depression differs depending on whether researchers consider purely symptom reduction, or also take into account other factors related to improved functioning. For example, researchers found when consideration was given to "life adjustment" rather than only symptom reduction, those people who had received either interpersonal therapy (IPT) or cognitive therapy (CT) for depression (in the NIMH-TDCRP) had fared significantly better than people who had received either medication and clinical management or placebo and clinical management (Zuroff, Blatt, Krupnick & Sotsky, 2003). That is, clients who received IPT or CT reported feeling better able to cope with life circumstances and with managing the symptoms of depression when they occurred, whereas people in the other treatment groups did not report the same improvements in life adjustment.

Zuroff, Blatt, Krupnick and Sotsky (2003) aptly pointed out that the reduction of symptoms is only one of the goals of psychotherapy and other treatments of depression. They comment that while the currently common short-term treatments of depression are generally successful in reducing patient symptoms, relapse and recurrent depression is all-too-common.

Many patients will not remain symptom-free after receiving treatment. Blatt and Zuroff (2005; see also Luyten, Blatt, Van Houdenhove & Corveleyn, 2006; Consumer Reports, 2004) are among a growing chorus of voices expressing concern over the negative impact of short-term treatment approaches to depression.

Models of Depressive Vulnerability

There are many different models of depressive vulnerability that are based on intrapersonal and interpersonal factors. Theorists conceptualize the causes and consequences of depression in a number of different ways. Several prominent approaches will be discussed below.

Personality and Vulnerability to Depression

In contrast to the approach taken by the authors of the DSM-IV (APA, 2000), a number of theorists and researchers have hypothesized that vulnerability to depression is correlated with personality style. That is, when faced with similar life events, people with different personalities will respond differently and be affected differently. One person might develop depression when faced with adverse life events, while another might be relatively unaffected. Thus, rather than depression resulting from solely biological factors or unfavorable experiences, here it is believed to develop because of the interaction between individual differences in personality and negative life experiences.

One example of how personality style is theorized to interact with life events to create depression comes from the work of Arieti and Bemporad (1980). In their interpersonal perspective, they distinguished between a "dominant other" and "dominant goal" type of depression. The dominant-other type of depression centers around the desire to receive passive gratification from another person. When interpersonal losses or threats of loss occur, an individual with a "dominant other" personality responds by becoming clingy, demanding, dependent, and infantile. In the dominant-goal type of depression, the person is more focused on assurances of self-worth and on becoming free from guilt. Achievement of a goal is the means

by which the person attempts to regain love and approval from important others. Depression is theorized to result when goal achievement is thwarted.

The Congruency Hypothesis

How is it that two different people can both develop depression in response to different histories and life events? How is it that their response to intervention differs and signs of improvement are also dissimilar? Blatt and Zuroff (1992) and Beck (1983) conceptualize predisposition to depression as resulting from an interaction between stable personality traits and fluctuating states, in response to specific life-events (Zuroff, Blatt, Sanislow, Bondi & Pilkonis, 1999). People with a particular personality type are believed to develop a specific type of depression in response to certain kinds of events. This has been referred to as the congruency hypothesis (Beck, 1983; Blatt, 2004; Blatt et al, 1982 – in Bartelstone & Trull, 1995; Santor & Zuroff, 1997). The essence of the congruency hypothesis is a twofold prediction: (a) individuals who are focused on interpersonal relationships are more prone to developing depression in response to events that cause or threaten the loss of their interpersonal relationships, and (b) individuals who are focused on issues of self-definition and self-worth are more prone to developing depression in response to (perceived) achievement failures.

Researchers have had mixed results when seeking empirical support for the congruency hypothesis (Bartelstone & Trull, 1995; Santor & Zuroff, 1997). Individuals higher on measures of interpersonal relatedness appeared more sensitive to interpersonal loss issues and more likely to develop dysphoric moods as a result of them. However, the results were mixed for those people with high scores on measures of self-criticism, who are believed to be highly focused on issues of self-definition. Researchers found that highly self-critical people were also negatively affected by interpersonal losses, not just achievement failures (Mongrain, 1998; Priel & Shahar, 2000; Shahar, 2001). The argument has also been made that self-critical people may perceive interpersonal difficulties as reflecting a kind of failure on their parts and/or their inability to be perfect.

Beck's Model

As mentioned earlier, Beck and Blatt preferred theories of depression that focused on causal factors in its development, rather than on symptomatology. Beck (1987, 1991) developed a cognitive theory of depression. He theorized that depression was often due to the persistent negativity of people's cognitions, expectations and interpretations of events (Haaga & Beck, 1995). He suggested that these negative cognitions are often distorted, and that depressed individuals appear biased toward negative interpretations of events. Consequently, Beck's approach to therapy has been to focus on changing distorted cognitions, challenging irrational beliefs and so on.

Beck (1987, 1991) viewed depression in part as stemming from personality styles developed in infancy and childhood. In particular, two types of individual styles were hypothesized to be distal contributors to reactive depression; sociotropy and autonomy. His construct of sociotropy (described in Clark, Steer, Beck & Ross, 1995; also in Zuroff, Mongrain & Santor, 2004) refers to the degree to which an individual invests in positive interactions with others. Those who place excessive value on interpersonal relationships and spend a considerable amount of time trying to ensure they feel loved, cared for and accepted by others are described in Beck's formulation as highly sociotropic. People who are less concerned with or focused on their interpersonal relationships and are instead highly invested in being independent are described as highly autonomous. "Highly autonomous individuals believe that they must demonstrate superior levels of accomplishment and self-control to demonstrate their sense of mastery and independence" (Clark, Steer, Beck & Ross, 1995, p. 325)

Sociotropy, Autonomy and Depression. Beck (1987, 1999) and his colleagues theorized that a person can have attributes of sociotropy or autonomy without being depressed. However, being excessively autonomous or sociotropic is theorized by Beck and his colleagues to be associated with depression, albeit in different forms (Clark, et al, 1995). The highly sociotropic individual is thought to develop depression in response to

life stressors in the form of interpersonal losses, such as the death of a loved one or other loss of social resources. The highly autonomous individual is believed to be at increased risk of depression in situations where independence is threatened and/or the achievement of goals is thwarted. Clark et al (1995) acknowledge that research results on the link between sociotropy, autonomy and depression have been mixed.

Sociotropy, as measured by the Sociotropy-Autonomy Scale (SAS; Beck, Epstein & Harrison, 1983), has received fairly consistent support in research findings. It has been found to correlate consistently with other measures of interpersonal dependence, such as the Depressive Experiences Questionnaire – Dependency subscale (discussed below) and the Dysfunctional Attitude Scale – Approval By Others subscale (DAS; Barnett & Gotlib, 1988), as well as with measures of depression and anxiety. As such, it lends support to Beck's conceptualization of depression, cognition and personality style.

The Autonomy construct, as measured by the SAS has received much more equivocal support (e.g., Blaney & Kutcher, 1991; Blatt & Homann, 1992; Clark et al, 1995; Dunkley, Blankstein, Zuroff, Lecce & Hui, 2006a, 2006b; Shahar, Blatt, Zuroff, Kuperminc & Leadbeater, 2004; Zuroff & Fitzpatrick, 1995; Zuroff, Mongrain & Santor, 2004) from the research. It has not been found to consistently correlate with other similar constructs, such as the DEQ – Self-Criticism subscale or the DAS – Performance Evaluation subscale, nor has it been found to reliably correlate with depression. Blatt and Homann (1992) suggested the SAS – Autonomy subscale seems to measure counter-dependency more than excessive autonomy. The processes that measurement of Autonomy seems to tap into do not appear to be strongly related to either the presence of depression or proneness to developing it.

Blatt's Model of Depressive Personality Types

The idea that cognitive vulnerability for depression has received considerable empirical support, but the social contexts of those people who become depressed also need to be taken into consideration (Giesler & Swann, 1999; Hankin, 2005; Mongrain, 1998; Shahar, Blatt, Zuroff, Kuperminc

& Leadbeater, 2004). One theory that takes into account early life experiences, personality development and current social context is that of Blatt (2004; Blatt & Zuroff, 1992). Blatt theorized that people who were depressed could have different types of internal representations of self, others and their environment, and could inhabit specific social contexts that could contribute to their vulnerability to depression. He conceptualized depression as resulting from an interaction between one of two personality types and situational factors. These are outlined below.

Dependency. Coming from a psychodynamic perspective, Blatt (2004, Blatt & Zuroff, 1992) characterized depression as being either: "dependent" (or "anaclitic") or "self-critical" (or "introjective")[4]. Dependency, they believed, developed in infancy and early childhood, in response to particular parenting and attachment experiences (discussed below). The dependent person is thought to have a desperate need to maintain close interpersonal relationships, and his/her fears often centre around the loss of any of these relationships. Dependent people are reluctant to express anger at others or act in ways that would threaten their relationships with others. Blatt and Zuroff (1992; see also Blatt, 2004) theorized that dependent individuals were most likely to develop depression in response to loss or rejection in social relationships.

Dependent people tend to inhabit lives rich with social interaction and intimate interpersonal exchanges (Blatt & Zuroff, 1992; Mongrain, 1998; Mongrain, Vettese, Shuster & Kendal, 1998; Santor & Zuroff, 1997, 1998; Vettese & Mongrain, 2000; Zuroff, Moskowitz & Coté, 1999). Having a strong social support network has often been shown to act as a mediator, reducing the likelihood of developing depression. Mongrain (1998) noted that Dependency as a personality variable "...then would seem to have beneficial, pro-social outcomes that could serve to buffer the effects of stress. So how is Dependency a vulnerability factor for depression? ...

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[4] I will refer to these two types as "dependent" and "self-critical" throughout this paper. Some of the literature and research in this area uses the terms "anaclitic" and "introjective," respectively. The terms are interchangeable in the literature.

dependent individuals may be vulnerable to depression following the perception of interpersonal loss" (p. 169).

The behaviours that a Dependent person engages in when undergoing a loss or feeling their interpersonal relationships are threatened may eventually elicit more negative responses and withdrawal of support from others, leading them to behave even more dependently. This pattern may serve to perpetuate the dependent person's fears of loss and increase the risk of future depression. For instance, while their dependent behaviour may initially evoke a supportive external response from others, there may be an underlying negative reaction and subsequent lessened support.

These kinds of observations have led to further exploration of the trait of Dependency. It has been shown to be comprised of two subtypes: "neediness" and "connectedness" (Dunkley, Blankstein, Zuroff, Lecce & Hui, 2006b; Vettese & Mongrain, 2000; Zuroff, Moskowitz & Coté, 1999). Neediness appears to be associated with more negative affect and higher levels of depression. Vettese and Mongrain (2000) characterize neediness as a less mature type of Dependency. Connectedness, which they designate as a more mature form of Dependency, has been associated with more positive, adaptive outcomes and is less likely to be strongly correlated with depression. So, some people may be quite connected, interdependent and close to others without displaying the more negative, needy, dependent behaviours associated with the maladaptive form of Dependency. Dunkley, Blankstein, Zuroff, Lecce and Hui (2006b) have further described the difference between dependency and connectedness as relating to the mutuality of the relationships one has. A Dependent person tends to view the other primarily as a means of meeting his/her own needs, where as a more highly Connected individual will engage others in more mutually satisfying and beneficial relationships.

Self-Criticism. The very self-critical person is considerably different from the highly dependent one (Blatt, 2004; Blatt & Zuroff, 1992). S/he is thought to be less concerned about interpersonal relationships, and more concerned with achievement and perfectionism. The highly self-critical person engages

in constant, harsh self-evaluation and scrutiny, and suffers from fears of disapproval. Highly self-critical individuals are often fearful they will lose the respect and acceptance of others. Feelings of guilt, unworthiness, inferiority and failure are common. They are often unable to enjoy their accomplishments and successes, even though they work hard and may achieve a great deal.

Fear of rejection can also colour the nature of the very self-critical person's relationships. He may remain somewhat distant and aloof from others in order to protect himself from potential rejection (Mongrain, Lubbers & Struthers, 2006). That cool, aloof stance may actually invite rejection from others. Recent research has begun to explore types of SC. Powers, Zuroff and Topciu (2004) developed a questionnaire to identify and explore overt or comparative SC with covert or internalized SC. Both types of SC were significantly correlated with depression. Whelton and Henkelman (2002) have begun exploring possible distinctions between negative and positive self-critical processes.

Research thus far has been fairly consistent in showing a relationship between both Dependency and Self-Criticism (SC) and depression. However, SC appears to have a stronger effect on the development of depression than Dependency does (Blatt, Shahar & Zuroff, 2002; Luthar & Blatt, 1993; Mongrain & Zuroff, 1994, 1995; Rector, Bagby, Segal, Joffe & Levitt, 2000).

Blatt and Zuroff (1992) have suggested that dependency and self-criticism are enduring personality traits that begin to develop early in life and remain a part of one's personality throughout adulthood. Support for their conceptualization of these two personality types as enduring traits has come from many different quarters. In studies of children and adolescents, for example, researchers have found the personality traits of dependency and self-criticism (e.g., Fichman, Koestner & Zuroff, 1996; Galambos, Leadbeater & Barker, 2004; Kuperminc, Blatt, Shahar, Henrich & Leadbeater, 2004; Luthar & Blatt, 1993; Shahar, Blatt, Zuroff, Kuperminc & Leadbeater, 2004; Shahar, Gallagher, Blatt, Kuperminc & Leadbeater, 2004; Shahar, Henrich, Blatt, Ryan

& Little, 2003; Shahar, Henrich, Winokur, Blatt, Kuperminc & Leadbeater, 2006; Thompson & Zuroff, 1998, 1999a, 1999b). In these studies, both personality traits, but especially SC, were associated with depression. In a study of the degree of stability of these personality traits in adults, Bagby, Shuller, Parker, Levitt, Joffe, and Shafir (1994) found that neither Dependency nor SC was significantly affected by changes in patients' depressed mood after treatment, and that recovered patients continued to show higher levels of Dependency and SC than comparison individuals.

Support for Blatt and Zuroff's Theoretical Conceptualizations

In this section, I will provide some specific examples of research that has supported Blatt and Zuroff's (1992) theory. However, most of the research cited in the rest of the literature review on dependency, self-criticism and depression would also fit here. It is important for the reader to keep in mind that while SC is highly correlated with depression, it is not the same as depression (Shahar, Henrich, Winokur, Blatt, Kuperminc & Leadbeater, 2006). Individuals who are self-critical may not be depressed and vice-versa.

Support for the contention that different types of individuals experience different types of depression and respond to interpersonal events differently has come from many diverse studies. For example, Santor and Zuroff (1997, 1998) conducted an experiment in which they threatened the perceived status of some women by giving them false feedback that they had performed poorly compared to others, including a friend, on a task. The women were then given the choice to use feedback they believed came from their friend. Santor and Zuroff found that women in their studies who had high scores on dependency tended to respond to events that threatened their perceived status by taking steps to preserve interpersonal relatedness. That is, they acted in ways that were more beneficial for their friendships than for correct performance of the task. In contrast, participants high in SC were generally more motivated to attempt to preserve self-definition and promote self-worth when their status was threatened. In other

words, highly self-critical women were more likely to put their performance ahead of their friendships.

Santor and Zuroff (1997, 1998) also found that interpersonal events strongly influenced the moods of college students. Outperforming friends tended to bolster mood, while being outperformed by friends depressed participants' mood. Similarly, Zuroff, Blatt, Sanislow, Bondi and Pilkonis (1999), in their analyses of the NIMH-TDCRP data, found support for the conclusion that vulnerability to depression results from an interaction between personality traits and current states. They found that patients' dysfunctional attitudes (as measured by the Dysfunctional Attitude Scale) remained quite stable during and after treatment for depression, even when treatment appeared successful. Similarly, Shahar, Blatt, Henrich, Ryan and Little (2003) found support for the theoretical constructs of SC and dependency and their relationship to depression in a study of adolescents. Self-criticism was associated with fewer positive, protective, and pleasure-related processes. It was thought that this increased the risk of developing depression for adolescents.

The interpersonal problems of highly self-critical persons may start long before adulthood, and may be related to psychopathology other than depression (Clara, Cox & Enns, 2003). In addition to the constructs of SC, dependency and efficacy[5] being relevant to depression, they have been found to be related to other mental health issues as well (Shahar, Trower, Iqbal, Birchwood, Davidson, & Chadwick, 2004). Efficacy[6] is thought to relate to "general feelings of strength, resilience, and confidence..." (Shahar, Trower et al, 2004, p. 481). Shahar and Trower, et al (2004) found these three factors could be meaningfully related to acute and severe psychosis. "Dependency had a greater role in symptoms and illness-related beliefs than self-criticism" (Shahar, Trower, et al, 2004, p.485).

Developmental Processes, Attachment, Self-Criticism and Dependence

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[5] Efficacy is having "...a sense of confidence in his or her own resources and capabilities, with high standards, and a conviction of being able to meet them" (Viglione et al., 1990, p. 54).
[6] For more information on Efficacy, please see the section on the Depressive Experiences Questionnaire in Chapter Three.

Developmental processes

Blatt and Zuroff (1992, Blatt & Blass, 1996; Blatt & Homann, 1992) theorized that dependency and self-criticism arise out of normal personality development processes. They described personality development "...as evolving from a complex dialectic transaction between two fundamental developmental processes: (a) relatedness – the development of increasingly stable, enduring, and mutually satisfying interpersonal relationships; and (b) self-definition – the development of a differentiated, consolidated, stable, realistic, essentially positive, and integrated self-definition or identity" (Blatt & Blass, 1996, p. 309).

In a number of studies, Blatt and Zuroff and their colleagues (these will be delineated below; see also Clara, Cox & Enns, 2003; Zuroff, 1994) have obtained confirmation for Blatt's theory linking dependent and self-critical personality styles to depression. It also seems probable that these personality traits transcend culture and ethnic boundaries. There is a small but growing body of research (e.g., Kuperminc, Blatt, Shahar, Henrich and Leadbeater, 2004) that provides cross cultural evidence to support the theory that people do go through these two types of personality development.

Linking Attachment, Personality Styles and Depression

Attachment, Self-Criticism and Dependency. Attachment refers to the bond that develops between an infant and her/his caregiver. Bowlby (1977) was one of the first to describe attachments between parents and their children, the different ways in which they are formed and the physical, social, behavioural and emotional manifestations of those attachments (Alford, Lyddon & Schreiber, 2006). Early attachment experiences were theorized to impact later close relationships, as well as a host of other areas of an individual's life (Fraley, Niedenthal, Marks, Brumbaugh & Vicary, 2006). Most recently, work has begun on exploring adult attachments (Alford et al, 2006; Fraley et al, 2006).

Attachment and early childhood experiences are believed to be central to the courses that these two linked paths of development (relatedness and self definition) take in any individual (Blatt & Homann, 1992;

Koestner, Zuroff & Powers, 1991; Porcerelli, Shahar, Blatt, Ford, Mezza & Greenlee, 2006; Zuroff & Fitzpatrick, 1995). Individual attachment styles appear to be quite stable over time. In a study of a Turkish sample, Imamoğlu and Imamoğlu (2006) found that attachment styles forged in infancy and early childhood influenced long-term attachment styles in both peer and romantic relationships. They found support for the idea that attachment styles are long-term, enduring traits but that they can vary across contexts and relationships. Their research (along with others, e.g., Alonso-Arbiol, Shaver & Yarnoz, 2002) also supported the cross cultural applicability of the concept of attachment.

Building on research linking early attachment experiences with the development of emotional self-regulation, Alford, Lyddon, and Schreiber (2006) found different attachment styles were associated with different levels of positive and negative emotions in adults (see also Mikulincer & Shaver, 2005b). Positive emotional patterns tended to be higher for individuals in their study with secure attachment styles. Obegi, Morrison and Shaver (2004) found evidence that attachment styles can sometimes be transmitted intergenerationally, especially between mothers and daughters.

Meyers and Pilkonis (2002) described attachment styles as very enduring. They reported on a study in which attachment styles classified at age 12 months were still highly likely to be the same 20 years later (72% of those initially classified retained their original classification). They further noted that "... changes in attachment could usually be explained by the occurrence of negative life events..." (p. 368). Hankin (2005) discovered that "an insecure attachment style, a negative cognitive style, and negative events helped to account for the link between childhood maltreatment and later depressive symptoms in young adulthood" (p. 645). He hypothesized and found support for the contention that childhood maltreatment increased the likelihood of developing an insecure attachment, and also of developing depression as an adult.

Secure Attachment. Securely attached people (children or adults) are thought to be comfortable with trusting others. They are able to depend

on others and do not experience excessive worries of abandonment or rejection. They do not fear intimacy. They have been found to generally have a fairly positive outlook on life and be resilient in the face of difficulties. Their interpersonal relationships are relatively trouble-free.

It has been shown (for a review of some of the literature, see Blatt & Homann, 1992; also Meyers & Pilkonis, 2002; Mikulincer & Shaver, 2005a[7]) that securely attached individuals have experienced consistent care and attention, nurturance and support from their caregivers. Appropriate autonomy has been encouraged, and caregivers have been consistently responsive to their needs, as well as matching their mood. Securely attached individuals appear unlikely to develop high levels of either Dependency or SC. Throughout their infancy, childhood and adolescence, securely attached people have experienced positive, supportive relationships with others. At least one significant relationship has been stable and mutually satisfying. They have also had opportunities to develop a sense of themselves as capable individuals, and they have a stable, positive sense of self-worth. People with secure attachment styles also report fewer symptoms of ill health than those with insecure attachment styles and experience less negative affect than insecurely attached individuals (Armitage & Harris, 2006).

Insecure Attachment. When caregivers are inconsistently caring, nurturant or supportive; when autonomy is either thwarted or enforced too soon; and/or when caregivers are harsh, punitive, critical, withholding or rejecting, the infant or child will develop an insecure attachment to her/his caregivers (Blatt & Homann, 1992). Two types of insecure attachment that have been identified in the literature are noteworthy here: (a) anxious-insecure, and (b) avoidant-insecure (Blatt & Homann, 1992; Meyers & Pilkonis, 2002). Insecurely attached adults (of either type) are at greater risk for depression (Hankin, 2005; Shaver, Schachner & Mikulincer, 2005). Bartz

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[7] For extensive research on attachment, please refer to the work of Cindy Hazan, Mario Mikulincer, and/or Phillip R. Shaver, and their colleagues.

and Lydon (2006) found that attachment styles were related to relative comfort or anxiety in interpersonal relationships.

Anxiously-insecure people are thought to have had inconsistently available caregivers as infants (Blatt & Homann, 1992). They apparently become preoccupied with dependency on their parents as they mature. They seem to have no sense of certainty that their parents will continue to provide care and support, so they are constantly seeking reassurances of that. Maintaining contact with caregivers is a significant focus in their lives. Anxiously insecure children show a great deal of similarity in affect and behaviour with dependently depressed adults. Lopez, Mauricio, Gormley, Simko and Berger (2001) noted that anxiously attached individuals tended to be very attentive to their feelings of distress, and to express these quite readily, whereas individuals with avoidant attachment styles (see below) were more likely to isolate themselves and repress their disturbing emotions rather than express them.

Avoidantly-insecure infants and children appear to place little value or concern on their attachment relationships (Blatt & Homann, 1992). Their parents seem to have been inattentive or unresponsive to their requests for closeness and attention. Blatt and Homann (1992), in reviewing some of the attachment research, noted that children who had been insecure-avoidant as infants were still showing avoidant responses to family interactions at age six. Being rejected and having parents who also avoid intimate contact (Blatt & Homann, 1992; Koestner, Zuroff & Powers, 1991) appears to contribute to the development of avoidantly-insecure attachments. In a similar vein, parents with very avoidant attachment styles were less responsive to their highly distressed children than low avoidant parents (Edelstein, Alexander, Shaver, Shaaf, Quas, Lovas & Goodman, 2004). Holmes and Lyons-Ruth (2006) found that mothers who had insecure and profoundly distrustful attachment styles were more hostile, intrusive and negative towards their infants.

Avoidant-insecure attachment may be expressed in children and adolescents as aloofness and a tendency to focus on activities and efforts

to show autonomy and self-worth. Significant others are not trusted to be consistently available either emotionally or physically. They tend to approach new relationships quite cautiously, which may perpetuate the distance and disconnectedness they have come to expect. Individuals with an avoidant style were also found to be reluctant to make positive judgments about others and somewhat resistant to changing negative judgments (Zhang & Hazan, 2002). Zuroff and Fitzpatrick (1995) reported that the available evidence suggests a link between insecure-avoidant attachment and adult self-criticism. Thus, the path would appear to lead from negative early attachment experiences to dependent and self-critical personality traits to negative life events, and subsequently to depression. This will be explicated more clearly below.

Linking Attachment, Personality Styles and Depression. There is also evidence that depression can be transmitted intergenerationally within families. Depressed parents create home environments that foster the development of depression in their children, above and beyond what could be attributed to genetic predisposition. Blatt and Homann (1992), in their review of the literature on parent-child interactions and the etiology of depression, noted that children raised by clinically depressed mothers were at increased risk of developing psychopathology later in life, especially depression. Numerous other behaviour problems, such as hyperactivity, anxiety, delinquency and substance abuse, are also often seen in children with depressed parents. The authors speculated these behaviours might have been masked expressions of the children's depression[8]. Furthermore, in their review, Blatt and Homann (1992; see also the review by Huprich & Greenberg, 2003) found that children raised by depressed mothers were likely to subsequently create similar homes for their own families.

Heim, Plotsky and Nemeroff (2004) provide some of the physiological evidence linking attachment and depression. They conducted a meta-analysis of studies linking early adverse experiences to depression. They

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[8] Although it is beyond the scope of this review, research tends to support the theory that negative acting out is a common symptom of depression in children, adolescents, and even sometimes adults.

found changes in the structure and function of the brain that occurred as a result of adverse early-life experiences such as abuse and neglect. Abuse and neglect are believed to contribute to the formation of insecure attachments. The neurobiological changes in the brain that these negative experiences created were then linked to increased likelihood of developing depression later in life.

Huprich and Greenberg (2003) reviewed a variety of research that showed that "the quality of earlier relationships is related to that of present day relationships and functioning" (p. 677). Using object relations theory, they described how early relationships create a 'template' for later relationships through an internalized 'object' such as one's parent or caregiver. Research by Koestner, Zuroff and Powers (1991) also supports Blatt's theoretical formulation of depression as in part resulting from early parenting experiences. They found that restrictive and rejecting parenting from the same-sex parent was associated with the development of self-criticism in adolescents. They also discovered that self-critical traits were quite stable for women from adolescence into adulthood.

The work of Zuroff and Fitzpatrick (1995) further showed that self-criticism in adults was correlated with a fearfully avoidant attachment style. That is to say, they found that self-critical individuals avoided attachment and intimacy out of fears of rejection, criticism and anticipated negative reactions of others, rather than because they placed little value or importance on close relationships or because they over-valued independence and self-reliance. Both dependency and self-criticism have been linked to insecure attachment styles (Blatt & Levy, 2003; Levy, Blatt & Shaver, 1998; Blatt & Shahar, 2004b). These studies found that dependency tends to be associated with an anxious-insecure attachment style, while self-criticism was most often associated with an avoidant-insecure style.

As with attachment styles, which are forged early on and appear to remain fairly stable throughout one's life, Blatt (2004, Blatt & Zuroff, 1992) hypothesized that dependency and SC were enduring personality traits that

emerged in childhood and adolescence and persisted as a long-term phenomenon in adults.

Long-Term Stability of Self-Criticism and Dependency

Development of these Traits. In this next section, I will review some of the research on SC and dependency that has been conducted with children and adolescents. These studies tend to show the appearance of SC and dependency traits in childhood and adolescence, and continuing on into adulthood. Moreover, indications are that these traits are associated with increased risks of depression and other emotional and behavioral problems in adolescents. Thompson and Zuroff (1998, 1999a, 1999b) conducted a study involving mothers and their adolescent sons and daughters. In one portion of the study (1998), based on the observed behaviours and affective rating scales completed by the mothers, they concluded that mothers who were high in SC or Dependency tended to relate to their daughters in ways that would cultivate those same traits in their daughters. Dependent mothers tended to thwart daughters' attempts at autonomy. Self-critical mothers tended to give negative feedback and be controlling and punitive.

Thompson & Zuroff (1999a) identified a path from maternal behaviour to the development of SC in adolescent girls. On the basis of their results, they hypothesized that mothers who are dissatisfied with their daughters in some way may tend to be cold, harsh, critical and punitive of their daughters. The lack of warmth and acceptance and harsh treatment may then lead to the development of an insecure attachment in the daughter. The insecure attachment then has the potential to develop into SC. In a complementary study, Thompson and Zuroff (1999b) found that mothers who scored high on the Dependency factor of the DEQ interacted with their less competent sons in ways that fostered dependency and may have thwarted their sons' attempts at autonomy. These findings point to the link between childhood experiences and the development of traits of SC and dependency.

As noted above, being self-critical seems to contribute to negative parenting practices, which could contribute to conflict within families (Holmes & Lyons-Ruth, 2006; Thompson & Zuroff, 1998). Thompson and Zuroff (1998) found that mothers who were highly self-critical were more controlling and punitive than mothers who were low in SC. They gave their daughters more negative feedback than other mothers in the study. These negative behaviours may be more pronounced when mothers are dealing with same-sex children, than with their male offspring.

In other research with adolescents, Fichman, Koestner and Zuroff (1996) found that self-criticism was positively related to depression, while dependency was not. Self-criticism was also associated with the tendency to exaggerate one's weaknesses in social and athletic spheres. Dependency and SC were found to sometimes interact in adolescence to create even more depressive symptoms and behaviour problems than either one alone (Shahar, Gallagher, Blatt, Kuperminc & Leadbeater, 2004). Efficacy was found to have a moderating effect, lessening the impact of either Dependency or SC. Luthar and Blatt (1993) also found associations between SC in adolescents and depression, as well as concerns about loss of approval. They found that dependency was strongly associated with tendencies to worry and to be sensitive to interpersonal cues. The work of Kawamura, Frost and Harmatz (2002) suggests that self-critical perfectionism may develop in adolescents from other cultures in a similar manner to that which occurs in White, North American culture.

In a study of adolescents, Blatt, Hart, Quinlan, Leadbeater and Auerbach (1993) found that both male and female teenagers who were high in self-critical dysphoria were more likely to report engaging externalizing behaviours such as delinquency and aggression. Similarly, Kuperminc, Blatt and Leadbeater (1997) found that higher levels of self-criticism in teens were associated with more self-reported internalizing and externalizing problems. While adolescents who are highly dependent or highly self-critical may both tend to feel a sense of vulnerability to external forces, and so a sense of powerlessness in their lives, self-critical teens may

feel more personal responsibility for negative life events (Luthar & Blatt, 1993).

Taken together, these studies demonstrate probable links between parental behaviour, childhood experiences, SC, Dependency, and subsequent depression. One can also see the lasting nature of dependency and self-criticism. They may initially appear as forms of insecure attachment in infancy and childhood, and begin to show more stability as personality traits by adolescence. Based on their review, Blatt and Homann (1992) concluded that the available evidence supported the conclusion that avoidant attachment was instrumental in the development of self-critical attitudes, and that anxious attachment resulted in excessive dependency. This was evident in childhood, adolescence and adulthood.

Self-Criticism and Adult Relationships

Self-criticism has been shown to negatively impact adult interpersonal relationships. It has been theorized and has been shown that people who are highly self-critical may interact with others in ways that serve to maintain their SC, and create even more interpersonal distress for them (Mongrain, Lubbers & Struthers, 2004; Priel & Shahar, 2000; Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004; Shahar, Joiner, Zuroff & Blatt, 2004). The way a highly self-critical person interacts with others may also help create the context in which depression is more likely to occur. In the following paragraphs, I discuss what some of the research has revealed about how highly self-critical people interact with and react to others.

From the research done on adolescents, college students, and psychiatric and psychotherapy clients, the trait of self-criticism has been shown to affect interpersonal relationships in many different ways. Self-criticism has been shown to hamper academic achievement in adolescents, especially boys, even when not accompanied by depression (Shahar, Henrich, Winokur, Blatt, Kuperminc & Leadbeater, 2006). Self-critical college students were found to expect their parents to respond coldly toward them (Mongrain, 1998). Being highly self-critical has been associated with being less agreeable (Dunkley, Blankstein & Flett, 1997), being less willing

to accept suggestions from others and less willing to share resources with others (Santor & Zuroff, 1997; 1998), being less loving and more hostile in romantic relationships (Mongrain, Vettese, Shuster & Kendal, 1998), being more depressed and experiencing more interpersonal rejection than dependent individuals (Mongrain, Lubbers & Struthers, 2004), and being more quarrelsome (Zuroff, Moskowitz & Coté, 1999). Blatt and Homann (1992) noted that researchers had found that both dependency and SC, as measured by the DEQ, but especially self-critical depression were related to having a negative attributional style.

Self-Criticism and Social Stresses. Priel and Shahar (2000) found that dependent individuals were more likely to develop increased distress after experiencing interpersonal stress. However, self-critical people tended to report increased stress and decreased social support over time. The decreases in their social support partly explained the increases in stress that they experienced. What this finding suggests is that there is a person-environment interaction in the case of SC, whereby SC and subsequent depression are not brought only solely by external events, but partially create the negative events and the stress that serves to maintain them. This can be partly understood through the work of Dunkley and Blankstein (2000; Dunkley, Blankstein, Halsall, et al, 2000), who found that self-critical people engaged in maladaptive coping strategies such as emotional responses, self-blaming, fantasizing reactions, and avoidant coping, were more likely to have higher levels of distress and experience more daily hassles (i.e., they perceive minor irritations as more troubling than the average person does). Shahar, Joiner, Zuroff and Blatt (2003) found support for the theory that SC is a vulnerability factor for depression in their study of university students. It appeared that SC led to stressful life events, which in turn led to depression.

People who are highly self-critical may be more likely to be self-denigrating and negative in their feedback during social interactions (Vettese & Mongrain, 2000). Their behaviour in turn, seems to elicit more negative feedback from others, which likely contributes to their negative views of self and others, and to their vulnerability to depression. One

interpersonal pattern that may contribute to SC in women may be the tendency for them to be more hostile and less loving during conflict, and for their romantic partners to match them in these behaviours (Mongrain, Vettese, Shuster & Kendal, 1998).

Highly self-critical people also apparently find social interactions generally less pleasant than people who are low in SC do (Zuroff, Moskowitz & Coté, 1999). The findings of Zuroff, Stotland et al (1995) led them to hypothesize that self-critical people may tend to expose themselves to others who are unpleasant and critical. Their interpersonal behaviour may cause others to respond negatively, which contributes to their experiences of social interaction being generally less pleasant than others find. Sometimes, very self-critical people may criticize themselves in an attempt to elicit social support from others (Powers & Zuroff, 1988). This may work somewhat initially, but can backfire, with others responding more negatively to them as well as expressing more negative self-views of their own!

Being highly self-critical has been associated with perceiving oneself as having fewer social resources (Santor & Zuroff, 1997, 1998; Vettese & Mongrain, 2000; Zuroff, Stotland, Sweetman, Craig & Koestner, 1995). According to Mongrain (1998), even self-critical people in a non-clinical population tended not to view themselves as being situated within a strong and reliable social network. Self-critical people often believe they cannot count on others for help during difficulties. Lower levels of trust, less self-disclosure, and lower satisfaction with romantic partners are all hallmarks of SC (Zuroff & Fitzpatrick, 1995).

Santor, Pringle and Israeli (2000) studied how feedback on performance on a task that required joint participation affected the mood and interpersonal behaviour of the individual members of couples. They found that within couples, partners who were highly self-critical were more likely to engage in behaviours that disrupted cooperation and interpersonal relatedness with their partner after receiving negative feedback about the performance of the couple. Interestingly, self-criticism did not seem to have the same impact when the couple received positive feedback on their

performance. However, higher SC was associated with fewer agreeable comments no matter what the experimental condition.

Thompson and Zuroff (1999b) commented that while SC has negative affective and interpersonal effects for both men and women, the consequences are especially pronounced in women. They suggested this may be related to the fact that women seem more prone to developing dependency, while men are more likely to become self-critical. If this is true, self-criticism may be counter to gender expectations for women, thus resulting in more negative interpersonal outcomes for women who are high in SC.

Self-Criticism and Self-Definition. It is somewhat puzzling that self-critical individuals would appear to act in ways that maintain their SC and that seem to reinforce their negative beliefs about themselves. This phenomenon can be partially explained and comprehended through the work of Swann and his colleagues (e.g., Giesler & Swann, 1999; Swann & Pelham, 2002). They have examined views and perceptions people have of themselves, whether they are positive or negative, whether they are strongly held or not, whether they match the perspectives of others, and how differences in perceptions (between self and other) are experienced. They found that "people who are highly invested in their self-views (confidently held or personally important) are especially inclined to display a preference for verification of their self-views. ... Such preferences were somewhat stronger when the self-views were relatively negative" (p. 219). In other words, people who think poorly of themselves seem to prefer the company of others who hold a similar view of them. This could help explain why the interpersonal relationships of people who are very self-critical are often so problematic.

Giesler and Swann (1999) have hypothesized that part of the reason for the preference for negative appraisals from others is that for some individuals (e.g., very self-critical people), these views are congruent with their own. That is, the positive view by the other person does not match or 'fit' with the way the self-critical person views and experiences himself.

Incongruent, albeit positive, views may create distress and lead the individual to feel as though the other person does not understand him/her. In order to reduce internal distress, the individual may actively try to change the other's views of him, so they more closely match his own. Alternately, he may limit contact with someone who seems to hold an incongruent view of him. Thus, a self-critical person may gravitate towards others who provide reinforcement for his own expectations of rejection, harsh criticism, judgment and a lack of warmth and support.

Self-Criticism has consistently been associated with lower than average levels of positive affect and higher than average levels of negative affect (Dunkley, Zuroff & Blankstein, 2006; Mongrain & Zuroff, 1995; Zuroff, Moskowitz & Coté, 1999; Zuroff, Stotland, Sweetman, Craig & Koestner, 1995). For the majority of people, engaging in social interactions and taking steps to solve problems result in increases in positive affect. Highly self-critical individuals experience less positive affect from engaging in these behaviours than other people do. It appears that highly self-critical people, whether through predisposition or learned experiences, enjoy social interaction less and are able to receive fewer benefits from it. They also experience less positive affect when they use positive, proactive problem-solving, compared to others. As a result, they may be less motivated to use these strategies, and instead rely on the ones that serve to maintain SC and negative affect, such as avoidant coping or self-blaming.

It is not hard to see how being very critical of oneself and possibly others, expecting criticism and rejection from others, being cold and distant in relationships, expecting little help and support from others, and viewing self and others negatively, could disrupt interpersonal relationships and lead to self-critical individuals experiencing less interpersonal support as well as being less satisfied with their social support/resources. The above discussed research could also help explain why highly self-critical people tend to experience interacting with others as unpleasant. Their tendencies to be more controlling and punitive are most likely negatively experienced by others, leading others to also be less pleasant toward them. This body of

research provides many clues as to how SC serves to create a context in which a person is both more prone to depression and more likely to lack the social resources to buffer against negative experiences or life circumstances that could lead to depression.

Perfectionism versus Self-Criticism

In addition to the literature on SC, there is a growing body of research on perfectionism and its relationship to personality, functioning and depression-proneness. In fact, Blatt (1995) and Zuroff (Blatt & Zuroff, 2002), the principal researchers in the area of SC and depression, have written articles about perfectionism, as well as chapters in books. Like SC, some aspects of perfectionism are significantly predictive of depression (Cheng, 2001; Gencoz & Dinc, 2006; Powers, Zuroff & Topciu, 2004). The work by Hewitt and Flett and their colleagues (see for example Flett, Besser, Davis & Hewitt, 2003; Flett, Besser & Hewitt, 2005; Flett, Hewitt, Garshowitz & Martin, 1997; Hewitt & Flett, 2003; Hewitt, Flett & Ediger, 1996; Sherry, Hewitt, Flett & Harvey, 2003; Sherry, Hewitt, Flett, Lee-Baggley & Hall, 2007) showed a connection between perfectionism, stress and depressive symptoms. Their definition of perfectionism appeared to encompass aspects of both high personal standards and the tendency to engage in harsh self-criticism and evaluation. When Perfectionism is separated into the two different types[9] – Personal Standards Perfectionism (PSP) and Self-Critical Perfectionism (SCP) – the PS Perfectionism is often found to be more adaptive than the self-critical type (Dunkely, Blankstein et al, 2006a, 2006b; Shahar, 2006). Dunkley, Blankstein, Zuroff, Lecce and Hui (2006a) noted that SCP was associated with negative self-perceptions and a defensive orientation towards others, where as PSP "reflected active striving for high standards and achievement" (p. 409). Dunkley, Zuroff and Blankstein (2006) found that self-criticism was more strongly associated with higher negative affect, daily stress, lower perceived social support and lower positive affect than perfectionism. For the purposes of this paper, I have treated self-critical perfectionism as if it

[9] This approach where perfectionism is split into two separate components, is common in both the perfectionism literature of Hewitt and Flett, as well as the work of Dunkley, Blankstein and colleagues.

were SC, and have generally used the term SC in discussing both self-criticism and self-critical perfectionism.

Shahar, Blatt, Zuroff, Krupnick and Sotsky (2004) found that Perfectionism, particularly the self-critical type, was associated with poorer social relations outside of therapy. Conversely, they reported that when a self-critical person was able to constructively engage in a relation with a therapist, social relations with friends, family members and other significant others improved as well. These findings hint at how psychotherapy may be able to reduce the negative effects of SC on interpersonal relationships.

Self-Criticism and Psychotherapy

As has already been mentioned, being highly self-critical negatively impacts psychotherapy outcomes (Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004; Shahar, Henrich, Winokur, Blatt, Kuperminc & Leadbeater, 2006; Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow & Simmens, 2000), as well as clients' relationships with their therapists. Blatt, Quinlan, Pilkonis and Shea (1995) found that higher levels of pre-treatment (self-critical) perfectionism led to poorer outcomes in psychotherapy, regardless of whether the client received interpersonal therapy, cognitive-behavioural therapy, or pharmacotherapy and clinical management (Shahar, Blatt, Zuroff and Pilkonis, 2003, found similar results in their analysis of the NIMH-TDCRP).

The results of research by Rector, Bagby, Segal, Joffe and Levitt (2000) suggest that in order for psychotherapy for depression to be effective, client levels of SC need to be reduced over the course of therapy. Their work specifically focused on the use of cognitive therapy for depression in outpatients with unipolar, nonpsychotic major depression.

Blatt and Felsen (1993) noted that in two separate studies, evidence was found that being either self-critical or dependent influenced outcomes in therapy for depression. In the first study (Blatt, Ford, Berman, Cook & Meyer, 1988), patients identified as self-critical tended to respond more readily to treatment and to show their improvements in reductions of clinical symptoms, whereas patients identified as dependent responded to

treatment more slowly and showed their improvements primarily in the quality of their interpersonal relationships.

In the second study, a reanalysis of the data from the Menninger Psychotherapy Research Project (Blatt, 1992; Blatt & Shahar, 2004b), researchers found that self-critical clients responded better to psychoanalysis, while dependent clients showed more improvement in psychotherapy. These findings strongly suggest there are important differences in depressed individuals at the outset of therapy that will significantly impact the outcome of therapy for them. It is therefore important when planning intervention/treatment, to identify whether a client shows more traits of SC or of Dependency.

The effect of clients' self-criticism on the therapeutic relationship will also be discussed further in the following section on the therapeutic alliance.

Therapeutic or Working Alliance

Although the relationship between therapist and client has been discussed since the days of Freud, it was not until the 1950's that empirical research into this relationship, which subsequently became known as either the "therapeutic alliance" or "working alliance[10]," began to be conducted in earnest. While considerable efforts were being made by various theorists, researchers and practitioners to prove which type of therapy was most effective, attention began to be paid to patient and therapist characteristics that might also be affecting treatment outcomes. Between 1977 and 2000, literally thousands of research publications on the working alliance were published (Horvath & Bedi, 2002).

In this section, I will begin by providing a brief history of the working alliance as it has been conceptualized and researched within psychotherapy. This will be followed by a discussion of the elements of the working alliance and the general findings of the research in this area. I will conclude this section by discussing what the research into the relationship between SC and the working alliance has shown thus far. Although the

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[10] I will use the terms "therapeutic alliance" and "working alliance" interchangeably, although there are those who distinguish between the two.

alliance is gaining recognition as an important factor in couples and family therapy (e.g., Horvath, 2000; Johnson, Ketring, Rohacs & Brewer, 2006; Johnson & Wright, 2002; Rait, 2000), as well as in supervision and training contexts (e.g., Horvath, 2000; Ladany, Walker & Melincoff, 2001; Ladany, Ellis & Friedlander, 1999), only the therapeutic alliance as it is understood in individual psychotherapy will be discussed here.

History of the Working Alliance

Many authors writing on the topic (e.g., Bordin, 1979; Hersoug, Monsen, Havik & Høglund, 2002; Horvath and Symonds, 1991) cite Greenson (1967) as the first to use the term "working alliance." In the context of psychotherapy, it referred to the positive collaboration between therapist and client, and came to be seen as a crucial component to successful therapy. Prior to the publication of Carl Roger's *Client-centered Therapy* in 1951, the relationship between therapist and client was not considered as important as technique and expertise in creating positive change in psychotherapy (Horvath, 2000). The relationship was most often understood in psychodynamic terms of transference and countertransference.

Taking a radically different approach, Carl Rogers (1957) and his colleagues focused on qualities of the therapist in affecting outcomes in counselling. They hypothesized that it was the therapist's ability to provide empathy, genuineness and unconditional positive regard that provided the *necessary and sufficient conditions* for positive client outcomes in therapy. Client characteristics were considered less important to the outcome of therapy (Horvath, 2000; Orlinsky & Rønnestad, 2000). Rogers and his colleagues believed that any client would benefit, grow and develop if the therapist were providing the right relationship conditions.

Rogers also took the courageous step of insisting his hypotheses about psychotherapy be put to the test of empirical validation. In the long run, after a great deal of research, it was concluded that the therapist-offered dimensions that Rogers identified were necessary but not sufficient conditions for therapeutic change (Orlinsky & Rønnestad, 2000). Orlinsky and Rønnestad none-the-less noted that when assessments of the therapeutic

relationship are made from the client's perspective, the cumulative research strongly supports the salience of the working alliance in predicting therapeutic outcomes.

In what came to be a landmark article about the dimensions of the counselling process, Bordin (1948, reprinted 2000) identified three central dimensions along which the counseling process might be considered: 1) the degree to which the client was given responsibility to decide on the problem in his/her own terms and to decide on the most appropriate way of resolving it, 2) how much attention and sensitivity to client attitudes and feelings was present in a counselor's responses to the client, and 3) the degree to which the emphasis in counseling was on intellectual processes and reasoning versus stimulating the client to further and deeper explorations of attitudes.

Elements of the Working Alliance

In a comment that proved prophetic, Bordin (1979) proposed, "the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not *the* key, to the change process" (p. 252, italics in original). He later went on to define the working alliance as consisting of three core components: (a) goals – both immediate and long-term, which are mutually agreed on by client and therapist, (b) tasks – which are the activities and change strategies that are undertaken during the course of counselling, and (c) bonds – the perceptions of mutual trust, acceptance, and confidence that client and therapist have of each other. In order to have a well-functioning relationship, both therapist and client need to agree that the tasks that form the essence of the therapeutic process are efficacious and appropriate. They must both value and endorse the goals and have a network of positive personal attachments between them (Bordin, 1979; Bordin 1948/2000; Horvath & Luborsky, 1993). Gaston (1990) synthesized the various definitions of the working alliance, including Bordin's, into a multi-dimensional, pan-theoretical construct with four main dimensions: the client's facility to work purposefully in therapy, his/her bond with the therapist, the therapist's involvement with and empathic

understanding of the client, and the agreement between client and therapist on goals and tasks.

Originally it had been hypothesized by some in the field of psychotherapy that the working alliance was most important in psychodynamically oriented therapies. However, Horvath and Symonds' (1991) findings show that it is just as important in other types of counselling. Presently, there are few if any models of psychotherapy that do not consider the therapeutic alliance an important component of psychotherapy process as well as being influential in treatment outcome.

Research on the working alliance has occurred in the context of the following types of therapy (among others): behavioural therapy, cognitive therapy, family therapy, gestalt therapy, and psychodynamically oriented therapy (reviewed in Horvath & Bedi, 2002; see also Norcross, 2002). In all of these therapies, the presence of a strong working alliance appears positively correlated with outcome. That is, when there is a strong alliance between client and therapist, there is a greater likelihood of positive outcomes from therapy. Contrasting alliance-outcomes across different types of therapy has not yielded any significant differences across treatment modalities (Horvath, 2000; Horvath & Bedi, 2002; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Orlinsky & Rønnestad, 2000; see also the work of Blatt, Zuroff and their colleagues in reviewing the data of the NIMH-TDCRP). Research on the effectiveness or superiority of different types of psychotherapy has led some investigators to assert that it is more important and productive to focus on patient/client characteristics that impact outcome (e.g., Blatt & Felsen, 1993; Hubble, Duncan & Miller, 1999) than to continue with efforts to prove one type of therapy's superiority over others.

Research Findings on the Working Alliance

The strength of the working alliance has been measured a number of different ways by researchers, including using client, therapist and observer sources and ratings (Horvath & Symonds, 1991). Horvath and Symonds' (1991) meta-analysis was one of the first to consider a large number of studies linking working alliance and outcomes in therapy. They found a

moderate but robust effect size linking therapeutic alliance and outcome in their review. This finding has since been replicated numerous times by other researchers. While not the single determinant of outcome that Rogers had hypothesized, the working alliance proved to be at least as important to outcome as the various techniques used by clinicians.

On the basis of their meta-analysis, Horvath and Symonds (1991) concluded that clients' and observers' ratings of the alliance were more predictive of outcome than therapists' (more recent summaries such as Horvath & Bedi, 2002, still concur with this finding). They suggested this may be due in part to a tendency on the part of therapists to overestimate the strength of the working alliance. Another possible reason they gave was that working alliance measures for therapists were often adaptations of those developed for clients, so that the measure is not really capturing the therapist's perspective on the relationship. It may also be partially due to differing expectations of therapy between client and therapist. Horvath and Symonds noted that clients often desire "speedy relief" from their psychological or interpersonal difficulties, whereas therapists may be focused on the more long-term benefits that could eventually accrue from the therapy, while recognizing but minimizing the more immediate discomfort that therapy may cause.

Both client and therapist are thought to contribute to the strength of the working alliance. Among psychodynamically oriented therapists, there had been debate about whether the relationship between client and therapist represented transference issues or a "real" relationship (Bordin, 1979; Horvath & Luborsky, 1993, see also Gelso, 2002). However, most conclude that the alliance is a real relationship in and of itself and believe it includes aspects of past experiences of both client and therapist, as well as facets of their current relationship (Chatoor & Krupnick, 2001). The findings of Hersoug et al (2002) suggest that once the early working alliance had been established, the impact of clients' past and current relationships on the alliance lessened.

Therapist Characteristics and Contributions to the Working Alliance

Ackerman and Hilsenroth (2003) reviewed a number of studies of therapist characteristics and techniques associated with a strong working alliance. They concluded that a therapist's ability to understand and relate to her/his clients and their experiences was likely an important component in creating a strong alliance. Being flexible, open, honest, respectful, trustworthy, interested, warm and confident were personal attributes of therapists that were found in their comprehensive review to have a positive effect on the working alliance. Techniques that were found to contribute positively to the alliance included reflection, exploration, accurate interpretation, noting past therapy successes, attending to the client's experience and facilitating the expression of emotion. Hubble, Duncan and Miller (1999) identified empathy as one of the most important therapist qualities. In addition to these qualities, Blatt, Sanislow, Zuroff and Pilkonis (1996) found that more effective therapists also expected therapy to take longer than less effective therapists did.

It has been noted that early alliance is a somewhat more powerful predictor of outcome than either later measures or the average measure of the alliance across sessions (Hersoug, Monsen, Havik & Høglund, 2002; Horvath & Bedi, 2002; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). The working alliance is thought to go through a series of ruptures and repairs over the normal course of therapy (Ackerman & Hilsenroth, 2003; Horvath & Luborsky, 1993; Safran, Crocker, McMain & Murray, 1990; Safran & Muran, 2000; Watson & Greenberg, 2000). A better working alliance is likely to result when ruptures are dealt with in an effective manner by both therapist and client. The therapist needs to focus attention on conflictual relationship patterns in therapy, and the client needs to respond to these challenges by involving him- or herself in the process rather than by avoidance.

There has also been debate about whether it is more beneficial to focus on past events or current relationship problems in psychotherapy. Horvath and Luborsky (1993) commented that therapists who addressed current ruptures in the therapeutic alliance were more likely to improve the

alliance and to facilitate achievement of therapeutic gains than those who offered interpretations of past events that had occurred outside the context of therapy.

It has been proposed that process and technique are not separate processes in psychotherapy. In other words, there is an interaction between the therapeutic alliance and the specific techniques used in therapy. The degree and amount of therapeutic progress is affected by the quality of the therapeutic relationship (Blatt, Zuroff, Quinlan & Pilkonis, 1996; Safran, Muran, Samstag & Stevens, 2001). The two influence one another and are interdependent. Beutler and Harwood (2002, also Hubble, Duncan & Miller, 1999) argued that therapist qualities, client characteristics, relationship factors, and interventions all work together synergistically to create an effect in therapy, and that it is false and arbitrary to separate these factors and attempt to examine them individually. Their research study suggested the therapeutic alliance cannot be understood without consideration for other factors, such as those identified above. However, most other researchers appear to accept that such things as therapeutic alliance and client characteristics, while influencing each other, can be examined and understood independently of one another.

Client Characteristics and the Working Alliance

There are a number of general client characteristics that are important to outcomes in therapy, as well as some that are more specific to highly self-critical clients. Perhaps somewhat surprisingly, severity of symptoms had only a small effect on the ability of clients to develop a good therapeutic alliance (Horvath & Bedi, 2002; Orlinsky & Rønnestad, 2000). The review by Horvath and Bedi (2002) of studies on working alliance led to the conclusion that clients who have difficulty maintaining social relationships, have poor family relationships, are defensive, and have little hope for success often have poorer therapeutic alliances (see also Hersoug, Monsen, Havik & Høglend, 2002). One of the most important predictors of positive outcome in therapy was client involvement in the therapy process (Hubble, Duncan & Miller, 1999).

In their analysis of the NIMH-TDCRP, Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins and Pilkonis (1996) found that what patients contributed to the therapeutic alliance was significantly predictive of outcome. Looking at the same data, Blatt, Zuroff, Quinlan and Pilkonis (1996) found that the patients' perceptions of the quality of the working alliance was an important predictor of symptom improvement, no matter what treatment had been received. Similarly, the patients' contributions to the working alliance also predicted whether or not an individual's symptoms would improve (Krupnick, Sotsky, et al, 1996; Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow & Simmens, 2000).

Shahar, Blatt, Zuroff and Pilkonis (2003), analyzing the results of the TDCRP found that the level or degree of patients' contribution to the therapeutic alliance and their satisfaction with their social relations was predicted by their levels of (self-critical) perfectionism. That is, those individuals with higher scores on measures of perfectionism were significantly less likely to contribute to the therapeutic alliance and were significantly less likely to be satisfied in their social relations. Those individuals with moderate levels of SC were found to be the most sensitive to the quality of the therapeutic relationship, regardless of the type of treatment they were receiving (Blatt, Zuroff, Quinlan & Pilkonis, 1996). Blatt and his colleagues hypothesized that highly self-critical clients may have been less able to change their negative mental representations of self and others during the course of therapy. When considering their analyses of the data from the NIMH-TDCRP, Blatt and Zuroff and their colleagues concluded that differences in outcome were more a consequence of the interpersonal characteristics of the therapeutic relationship than of the type of treatment provided. Reviewing data from the NIMH-TDCRP, Blatt and Zuroff (2005) found that pre-treatment (self-critical) perfectionism directly affected both the therapeutic relationship and treatment outcomes. In 2006, Zuroff and Blatt reported that a "positive early therapeutic relationship also predicted better adjustment" (p. 130) both during therapy and in an 18-month follow-up period. Layne, Porcerelli and Shahar (2006) used a case study example

to demonstrate how SC can impede in the development of the therapeutic alliance. They reported how the client's expectations that the therapist would be highly critical of her (as her parents had been) complicated treatment. Because of these negative expectations, it was more challenging to develop a strong therapeutic alliance.

Limitations of Previous Research and Goals of this Study

It seems there have been gaps in two main areas of the research on depression and SC. First, there is a dearth of longitudinal studies on self-criticism and subsequent depression. Longitudinal studies tend to be the most costly and difficult kinds of research to carry out. Koestner, Powers and Zuroff (1991) used longitudinal data that was gathered by previous researchers to explore the continuity of self-criticism from adolescence into adulthood. Blatt and Blass (1996) reviewed a great deal of research, including some longitudinal studies of attachment, in developing their dialectical model of personality development.

Priel and Shahar (2000) undertook a longitudinal study of dependency, self-criticism, social context and distress. They had a number of college students from several universities complete a number of self-report measures repeatedly over a nine-week interval. Their findings support the contention that self-critical individuals, through their behaviour, contribute to their own personal distress. Self-critical persons generated stressful events in their lives and refrained from accessing social support, which contributed to increasing distress.

Longitudinal studies are needed to shed some light on the development of SC in an individual and to establish a better understanding of the ways in which SC either lead to depression or predisposes an individual to developing depression in the face of failure or interpersonal difficulties.

There appears to have been few qualitative studies undertaken in this area (see for example, Galambos, Leadbeater & Barker, 2004; Layne, Porcerelli & Shahar, 2006). While research participants have filled out a myriad of questionnaires and self-report measures and on occasion been

videotaped or had their actions in other ways rated by observers, it would appear that researchers have rarely conducted in-depth interviews with any participants. Significant efforts need to be made to obtain an "insider's perspective" on the experience of self-criticism and its relationship to depression. This is particularly relevant in the case of the impact of client levels of pre-treatment self-criticism on the effectiveness and outcome of psychotherapy. As mentioned earlier, Shahar, Blatt, Zuroff and Pilkonis (2003) found that client pre-treatment self-criticism levels impacted the outcome of their therapy. Rector et al (2000) found similar results. Additionally, Rector et al found that successful responses to cognitive therapy were associated with significant reductions in SC levels.

Yet little is known about the thoughts, feelings and experiences self-critical clients are having in therapy. They have been given few opportunities to speak about it. Clients are also likely to be unaware of the negative consequences of SC in their personal lives and interpersonal relationships outside of therapy. The goal of this study has been to provide highly self-critical clients with the opportunity to talk about some of their experiences in psychotherapy that may be related to their SC and that appear to be affecting the strength of their relationship with their therapist. The participants were told the purpose of the interviews was to "explore and discuss the kinds of internal standards and internal dialogues people have and the kinds of self-evaluations people make, and how those things may be affecting the relationship between the client (that is, you) and the therapist" (See Appendix 'A'). By uncovering some of the inner processes that self-critical clients have and how these come into play during the psychotherapeutic process, perhaps SC can be better understood in the future. This could lead to SC being addressed more effectively in psychotherapy.

CHAPTER THREE
METHODOLOGY

Research typically is carried out when there is a desire or need for more information or greater understanding about a particular phenomenon, experience or event (Crotty, 1998). Once a research question has been formulated, the researcher must decide how to address that question. Crotty (1998) argues that the chosen research methods guide the researcher to a particular methodology. The methodology and method can direct the researcher to a particular theoretical framework and an epistemological stance. While Crotty (1998) goes from Methods to Methodology to Theoretical Perspective to Epistemology, in this chapter, I will do the reverse. The hope is that ending with the description of methods will aid in transitioning to reviewing the findings. I will start by considering the theoretical and epistemological stance that underpins my research, and then by describing the methodology I have chosen for this research. Lastly, the methods by which the data were collected will be described; how the participants were chosen, how they were approached, how the interviews were formatted, how they were transcribed, and finally, how they were analyzed. There will be a few detours along the way, as I describe measures and techniques that were used, along with the rationale for doing so.

The Epistemological Perspective that Guided This Research

The epistemological position a researcher takes will influence the kind of questions that researcher will ask. The epistemological stance taken provides the foundation for the kinds of knowledge that is accepted as possible, adequate and legitimate. This is also done in part to enable the researcher to present her findings in a defensible, convincing manner. Yet Crotty (1998) argues that while each research question requires a unique research methodology, it is important to learn how other researchers have approached other questions and why they did it in that way. "It awakens us to the ways of research we would never otherwise have conceived of. It

makes us so much more aware of what is *possible* in research" (Crotty, 1998, p. 14, italics in original). Locating the methods and methodology within a particular epistemological and theoretical stance helps the researcher justify what research was undertaken and the manner in which it was completed.

After the research question has been identified, Crotty (1998) states that the research process continues on to considering the research methods that may be effective in answering that question. The methods influence the methodology, which helps determine the best strategy to take with the research. The chosen methodology in turn guides the researcher to a particular theoretical framework and an epistemological stance. The researcher's theoretical perspective both influences and reflects how she sees the world, humans and social life. This provides the context for the research process.

This research was conducted within a constructionist epistemological framework. Constructionism takes the position that knowledge derives from meaning, and meaning is constructed by humans through their interactions in and with their world. Humans develop and communicate meaning "*...within an essentially social context*" (Crotty, 1998, p. 42, italics in original). The world is understood to exist in reality, it is 'always already there,' but meaningful representations of it are entirely human constructions (Spinelli, 1989). A constructionist perspective is fundamentally multi-perspectival. There is no objective, knowable, measurable world of meaning that can or should be identified and shared by all people. Furthermore, the constructionist view holds that meaning-making is a social activity and occurs within a complex social context; it is not imposed on the world by any one individual alone. Each of us is the products of our social milieu, and as such, the meaning we construct of ourselves and our world is influenced by the laws, rituals, customs and habits of our own society (Harré, 1993).

There are many possible methodologies that may be employed within a constructionist framework, along with numerous methods for each one (Crotty, 1998). People construct meaning in near infinite ways each day, within their social and personal spheres. Similarly, there are many

different ways to observe, record and understand the activities and interactions of ourselves and others. Constructionism holds that meaning and knowledge are neither objectively given nor completely subjectively created. Rather, they are the result of a give and take, a dialectical interaction between the individual and his/her social world and traditions (Crotty, 1998).

Theoretical Perspective

Using Crotty's (1998) framework, the theoretical perspective guiding this research is Interpretivism. "Interpretivists believe that reality is not objectively determined, but is socially constructed" (Kelliher, 2005). Interpretivism developed in reaction to positivism and logical empiricist methodology. The intent was to seek out "*...culturally derived and historically situated interpretations of the social life-world*" (Crotty, 1998, p. 67, italics in original). The roots of interpretivism are linked to Max Weber and his postulate that human sciences are concerned with "Verstehen" (understanding, Crotty, p. 67). Although Weber was concerned to some extent with causality, current interpretivist approaches are not.

Crotty (1998) placed hermeneutics within the tradition of Interpretivism. The word, "hermeneutics" comes from the Greek word for interpretation. Some understanding of hermeneutics is necessary to all approaches to qualitative research (McLeod, 2001). While hermeneutics was traditionally applied to religious texts, it has come to be applied much more broadly than to religious texts only, and encompasses more than merely written texts in qualitative research today (Crotty, 1998). Hermeneutics has come to be understood by some in a much more comprehensive sense: one might say that almost anything human from everyday behaviour to cultural artifacts, from dreams to cultic rituals, is the 'text' requiring interpretation (Ramberg & Gjesdal, 2005). However, interview transcripts still remain one of the most common type of 'text' interpreted hermeneutically. There is an assumption in hermeneutics that, in some ways, the text is "strange and far off" from the interpreter, and yet there is an affinity between the two – a common ground that will provide the

foundation of the emerging interpretation (Crotty, 1998, p. 90). In this particular instance, what was 'strange and far off' for this researcher were the individual experiences of each of the participants. My theoretical and personal understandings of SC provided some of the common ground for interpretation. In hermeneutics, texts are a method of conveying meaning, a practical and applied meaning. As such, this research was hermeneutic in that the intention was to develop findings that might have practical applications for working with self-critical therapy clients.

In the present case, the 'texts' to be interpreted were the interviews given by the eight participants. Informal conversations with participants and our social interactions during the research interviews also provided information that formed part of my interpretation. One aim of hermeneutics is to understand the 'text' in a deeper or different way than the 'author's' own understanding of the text. An assumption is that the author's meanings and intentions may be implicit and unacknowledged by the author him-/herself. "Interpreters may end up with an explicit awareness of meanings, and especially assumptions, that the authors themselves would have been unable to articulate" (Crotty, 1998, p. 91).

Methodology

There are a number of different possible approaches or methodologies that fit within a constructionist framework, including the Basic Interpretive Qualitative Analysis (BIQA) described by Merriam (1998, 2002). BIQA, described below, is particularly well-suited to a research study and design where there is a desire to interpret the 'texts' – in this case, the interviews – provided by a specific group of people, namely very self-critical psychotherapy clients. BIQA involves the use of relatively straightforward procedures, which enable the researcher to interview, interact with and talk to research participants. BIQA has been used within such diverse methodologies as hermeneutics, ethnography, and phenomenology (Merriam, 1998). Compatible with constructionist frameworks, it provides the opportunity for the researcher to identify themes that she found in her interviews without precluding the possibility that other themes and different

understandings might be obtained if another person conducted the interviews, analyzed them and/or developed the themes.

Basic Interpretive Qualitative Analysis

Merriam (2002) writes that a basic interpretive and descriptive qualitative study attempts to embody the following characteristics: a) "... the researchers strive to *understand the meaning* people have constructed about their world and their experiences..., b) ... the *researcher is the primary instrument* of data collection and data analysis..., c) ... the process is *inductive*, that is, researchers gather data to build concepts, hypotheses, or theories... and d) ... the product of a qualitative inquiry is *richly descriptive*" (Merriam, 2002, p. 4-5, italics in original).

Data collected for a basic interpretive qualitative study are inductively analyzed by the researcher. S/he seeks to inductively identify themes and patterns that cut across the data. It is one of the most common approaches used in qualitative research. In a basic interpretive study, elements from other types of qualitative traditions may be employed. For example, the constant comparative method described below, from grounded theory, is often utilized by researchers.

In a basic interpretive/descriptive study, analysis involves identifying patterns or themes that repeatedly appear in the data (Merriam, 2002). The first step is to develop meaning units from the interview transcripts, each one consisting of a single concept or point of the participant's experience. This is followed by "open coding" – categorizing the meaning units into clusters according to the meaning expressed in each cluster. These are given descriptive labels.

The researcher may then engage in two parallel processes: psychological reflection and constant comparative method. In psychological reflection, the researcher "attempts to immerse him or herself in the participants' world" (Elliott, Slatick & Urman, 2001, p. 81). The constant comparative method involves continually comparing and contrasting categories both within and across cases (McLeod, 2001).

There were several important reasons why I chose to use a basic interpretive research method as opposed to another one. This type of research with self-critical clients had to my knowledge never been done before. My research was therefore by its very nature exploratory. I was attempting to uncover basic themes and common experiences that self-critical clients have in therapy. I also wanted to use Interpersonal Process Recall (IPR – described below) to give a richness and immediacy to the interviews that might otherwise not be there.

The research I was conducting was located within an existing theory and research tradition on SC. Other principle research methods and methodologies available often had a larger, overarching purpose, which my research did not have. Grounded Theory did not seem appropriate because I was not attempting to develop a theory about SC. I was also not attempting to develop a theory of therapy with self-critical clients.

The Researcher as Instrument

In a qualitative research project, the person of the researcher is often very visible. Personal interest in the topic and prior understandings are considered important and relevant to discuss. McLeod (2001) wrote, "Every act of hermeneutic understanding begins with a pre-understanding, which orients the inquirer in relation to the text or topic" (p. 23). For this reason, I would like to share some of my own personal and professional reasons for having become interested in self-criticism and its impact in therapy. I would also like to suggest that past experiences as a researcher-in-training and therapist-in-training enabled me to obtain unique and useful data. To support this contention, I would point to the fact that my research participants disclosed information to me during our interviews that they had not in all cases shared with their therapists, whom they knew and had a much longer relationship with (see Chapter 4 for more information).

On a personal level, I have an interest in knowing more about self-criticism as a trait or tendency, where it may come from and how it can colour the lens through which a person views life. A friend once described me as engaging in "relentless self-appraisal." In fact, dealing effectively with

my own self-criticism has been a significant part of what was required for me to complete my research. I found many of the readings I have done ringing true of my own life. In terms of personal philosophy, obviously I 'believe' in the phenomenon of SC, and because of my own experiences, have ideas about how it might manifest itself in an individual's life.

There are some very real potential benefits I see for myself professionally from having engaged in this research. As a therapist-in-training, I have met and worked with self-critical individuals, and will likely meet many more in the years to come. Self-Criticism is often a very large aspect of the suffering that impels many clients to seek therapy. This research has given me some fascinating insights into what self-critical clients may be experiencing and how I might better support them to get the greatest possible benefit from therapy. It is hoped that I will not be the only therapist to benefit from this research, but I have a definite professional interest and stake here, as well.

Prior Understandings

Before I began this research, I wrote about many of my prior understandings about SC. It is important for the researcher, as the primary instrument of data collection and analysis, to situate herself in relation to the topic and the research question, and to provide a context that the findings and interpretations developed from. My foreknowledge and expectations regarding self-criticism and therapy have become something of a complex mix of my own personal history and experiences and the literature I have read for this research. I have included my prior understandings and foreknowledge in the final document to enable the reader to consider the findings in context.

Based on both my reading of the literature and my own experiences with SC, I strongly suspected that people who are highly self-critical tend to be critical of others – perhaps unwittingly, as well, which could contribute to their relationship difficulties. I thought it was likely unintentional and often even indirect, but the harsh personal standards they impose on themselves are likely also held for others to meet. Being around such a person could

leave one feeling like a disappointment or failure, because it would be hard to meet the standards the self-critical person has for him- or herself and others.

I suspected that the perfectionistic aspect of self-criticism also contributes to relationship problems. Inevitably, others disappoint us, or we them, and I wondered if those types of experiences do not lead to the self-critical individual withdrawing from a relationship (such as the therapeutic relationship), or ending efforts to contribute to the relationship. The self-critical person often may not have a lot of faith in others, and so may be reluctant to put energy into resolving issues. S/he may not have the skills to constructively resolve relationship difficulties and to use them as a means to actually strengthen relationships. Conflict appropriately dealt with can often strengthen interpersonal relationships and increase closeness, but a self-critical person may not be able to gain from these experiences.

Based on what I had read in the research and my own experience, I wondered if highly self-critical people maintain their fierce independence because they are so afraid of needing and depending on others. Fears of losing the love and support of others, not just their respect or approval, may keep self-critical people distant and cool in their relationships. It may not be that they do not want or need others, it may be that they are so afraid of needing too much or of being disappointed.

As indicated earlier, this research draws in part on the epistemology of hermeneutics, while not a hermeneutic endeavour in the strictest sense of the term. McLeod (2001) asserted that hermeneutics is the interpretation of a text, and that "...any text is created in a cultural-historical context, and then is interpreted in a different context" (p. 23). Therefore, there is another aspect of my historical and socio-cultural context that bears consideration, that of my education and training. Until beginning my graduate training in Counselling Psychology, I had been raised and educated in an objectivist/positivist ontology and epistemology. I was raised to believe and taught in my undergraduate courses that there was an objective, knowable truth that could be uncovered if one approached the task in the right

manner. Philosophically, I started out from an objectivist epistemology, which Crotty (1998) stated, "holds that meaning, and therefore meaningful reality, exists as such apart from the operation of any consciousness" (p. 8).

Through my experiences in my career prior to beginning graduate training, I learned that there is no one 'right' way to view the world, and that different perspectives are equally valid. The shift in my ontological perspective – my beliefs about the form and nature of reality and what can be known about it – and the epistemology that guided my efforts to make sense of myself, others and the world, continued throughout my graduate training. It was then that I first began to study non-positivist perspectives and qualitative research methods. The reason for this discussion is to acknowledge that for a great part of my life, I was strongly guided and influenced by an objectivist perspective, and a belief that there was an objective 'truth' available to someone who diligently sought it. This is a part of my history and no doubt in subtle ways may continue to influence my efforts at seeking knowledge and interpreting the world, including my research. As in my life, I have attempted in this research to maintain a consistently constructionist stance and approach to interpreting the data, but given my objectivist beginnings, I will likely continue to be influenced by this thought as well.

Trustworthiness

When the researcher is the primary instrument of data collection and analysis, as is often the case in qualitative research, a different approach must be taken to judging the quality of a piece of research than is typically taken in quantitative research. A number of qualitative researchers (e.g., see Patton, 2002, Oka & Shaw, 2000) use the concept of 'Trustworthiness' that was described by Lincoln and Guba (1985, 1986, cited in Patton, 2002). Lincoln and Gubd suggested that trustworthiness as it relates to qualitative research, was comprised of four components; credibility, transferability, dependability, and confirmability. Credibility could be thought of as analogous to 'internal validity,' and might be achieved through "prolonged engagement" with one's research or through "peer debriefing" (Oka &

Shaw, 2000). Transferability was suggested as the analog to external validity, and relates to how applicable the research findings were/are to another context. Dependability – a systematically followed process of conducting research – was analogous to reliability (Patton, 2002). Confirmability was suggested as the analog of objectivity, and relates to how the researcher shows the link between her assertions, interpretations and findings, and the data used to support them (Oka & Shaw, 2000).

McLeod (2001) noted that when research is hoped to have an impact on therapy practice, it is practitioners who often judge the adequacy of a particular piece of research. What is crucial is whether or not the researcher has "genuinely looked for examples and evidence that might contradict" her interpretation of the data (McLeod, 2001, p. 188). Are the interpretations plausible and trustworthy? McLeod comments that it is both the personal qualities of the researcher, her personal integrity, courage and commitment to the research task, as well as technical requirements that are important in establishing the trustworthiness of a piece of research. In the case of the present research, the following information is provided to help establish the trustworthiness of this research and the findings derived from it.

One reason I felt comfortable choosing a method of data collection that involved interviewing participants was because in my professional life, I had extensive practice in interviewing people in a variety of different settings for a variety of different reasons. As a child protection worker, I had learned how to interview children, parents, and other interested parties and professionals in matters relating to child protection. With children, it was important to quickly establish rapport so a child would feel comfortable to disclose experiences of abuse. Diplomacy combined with firmness was required when speaking to parents about allegations or concerns of abuse or neglect. I also needed to interview other individuals involved with the family to obtain further information and make decisions regarding a plan of action. I also spent a number of years working in families, where the ability to establish rapport while gathering important information and working therapeutically was a skill crucial to performing my job effectively. When I

entered graduate studies, I gained experience in interviewing in two different but related areas: research and therapy practice. In both of these settings, I developed skills at being sensitive to the interviewee, and at the same time choosing different threads of narratives to follow up on and explore further.

In conducting this research, I worked hard at being systematic, thorough and organized in handling the data and working on the interpretation. I extended my data gathering when important interview data were unusable, rather than attempt to 'make do' with fewer interviews. I used journaling to supplement the information collected during interviews. I analyzed the findings twice to ensure that I felt confident that my analysis seemed to me to represent the data I had collected. I discussed my interpretations with others, including supervisor and colleagues and obtained feedback from them about my interpretations. At times, they pointed out perspectives or interpretations that I had overlooked or approached differently. When possible, I went back to participants with my early interpretations and integrated their feedback into my findings. As will be shown in Chapters Four and Five, I also remained open to findings other than what I expected regarding SC. Finally, I included findings that were surprising and unexpected. These steps were all taken with the hope and intention of increasing the trustworthiness of the overall research study.

Methods

In this section, I will describe step-by-step how the data were collected. I will include information about how research participants were selected and contacted, about the student clinicians that worked with them, about our interviews and about the subsequent analysis.

My Dissertation Journal

From the beginning of the research process, when I started working on my Dissertation, I have kept a Dissertation Research Journal. There have been several purposes for this. Initially, I used it as a way to explore different ideas and possibilities for the research project. I have used it as a way to work through periods of being 'stuck' in the research process. Whatever the

block was, whether it was a frustration with writing (proposal or final draft) or a reluctance to call participants (they can't say 'no' if you haven't asked...), or an inability to make the sense I wanted out of my analysis, I tried to write through it. When I had an "Aha!" moment, where I had an inspiration about some part of my research, I described it and reveled in it in my journal.

I also took time after each interview to write down in my journal impressions and thoughts about the interview. I wrote about connections between the most recent interview and what I remembered or what stood out from interviews prior. My journal has been a friend and secret-keeper for me throughout this research process. My secret fears, frustrations and joys found their way into that journal, along with early analyses and a kind of bread-crumb trail that I have been able to follow back to the beginning of the journey. Information in my journal assisted me in identifying what I had learned from my "trial run" (see "Pilot IPR" section). Through my journaling, I was also able to peek back at interviews I was unable to transcribe (see "Technical Difficulties" section), and make some comparisons of my impressions of what those participants had shared compared to what I found in the final eight interviews that I transcribed and analyzed.

Identifying Potential Participants

Before beginning this research, I submitted an Application for Ethics Review of Proposed Research to the Faculties of Education and Extension Research Ethics Board. The study was approved on January 26, 2004.

Finding participants to interview for this research was a multi-step process. When individual adults contact the Education Clinic to request counselling, they are screened by a doctoral student, acting as an "Intake Worker," to ensure the appropriateness of the referral to the Clinic. Referrals are then assigned to students, who contact the clients and arrange a first session. Before going any further, let us consider the student therapists that my research participants were working with, and how I obtained the necessary therapist consent to proceed with my research project.

Enlisting Student Clinicians

As mentioned above, the research participants were all involved in counselling at a university counselling centre. Each participant was working with a student clinician. The student clinicians[11] were in the first year of either their Master's or Doctoral degree in Counselling Psychology. All had some prior experience in the 'helping' field, but most did not have extensive practice in counselling. They were not directly asked if they provided a specific type of counselling. The expectations of the educational setting were such that they were learning about and expecting to be trying a variety of different techniques and theoretical approaches. The information provided by participants about different interventions their student therapists used suggested to me an integrated, eclectic approach was common. In any case, the reader should think of these people as beginning therapists, whose style and orientation might still have been in a very formative stage.

At the beginning of the Winter Session 2004, and the Fall/Winter Session 2004/2005, I approached both the Master's and Doctoral counselling practicum classes. I explained my research, and the need for their consent to contact their clients because I would be requesting to use a videotape[12] of one of their therapy sessions to review with the research participants. I answered questions about the nature and process of the research and assured them that their participation was both voluntary and confidential. I explained how both their identities and that of their clients would be known only to me. This was possible because I transcribed the interviews myself, and in the process of transcription altered identifying information, including information regarding the therapist. Neither the professors nor the Teaching Assistants were present when students decided whether or not to consent. At no time were any professors (including my supervisor) or Teaching Assistants made aware of who had consented to allow their clients to be

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[11] I have also referred to them as 'student therapists' and 'student counsellors' in this document. These terms should be considered interchangeable in the present context.
[12] The videotape of the session was made by the student clinicians. It was/is common practice for both Master's and Ph.D. students to tape counselling sessions for the purposes of supervision. Each videotape was returned to the student clinician immediately following the completion of the research interview, to ensure confidentiality.

contacted and who had not. Consent among the student clinicians was high (near 100%). As it turned out, there were no occasions when I was unable – due to a student clinician's lack of consent – to contact a highly self-critical client to request participation in my research (See Appendix 'B').

Participants

It should be pointed out that at the Education Clinic as elsewhere, along the way there is always some attrition in the referrals for counselling. Sometimes people decide even before the Intake person contacts them that they no longer need or want counselling. Sometimes their situations have changed and/or improved by the time the Intake person or the student clinician contacts them. Sometimes, for reasons unknown, the Intake person or the student clinician is unable to contact them (e.g., the phone number is no longer in service or they are no longer at that number, etc). So, the population of therapy clients at the clinic differs from the general population and likely from the individuals who contacted the clinic but did not follow through with participating in therapy. None-the-less, the population might be fairly similar to other groups of people who obtain individual therapy.

During the first session, clients are given an Intake package with a number of questionnaires to complete. The purpose is to assess where the client is starting out and to get a sense of some of the presenting issues. This is an important step, because clients sometimes provide different information on written documents than they verbally give to their therapist. Often they are more forthright when writing about the problems they feel they are having. One of the forms that clients complete is the Depressive Experiences Questionnaire (DEQ – Blatt, D'Afflitti & Quinlan, 1976).

The decision to use the DEQ as a way to select participants was a relatively easy one. It was already being used in the clinic as an assessment tool for new adult clients. This self-report questionnaire has repeatedly been shown to be clinically useful as a heuristic tool, to help identify particular kinds of challenges that some individuals may face in their lives and in the course of therapy. The DEQ was an important measure in my research

because it contains a self-criticism scale, which was used to select potential research participants. In the past, a distinction has typically been made between qualitative and quantitative methods. Crotty (1998) argues that the divide should occur at the level of theoretical perspectives. He writes, "We should accept that, whatever research we engage in, it is possible for either qualitative methods or quantitative methods, or both, to serve our purposes" (p. 15). Therefore, choosing a quantitative measure to help select appropriate research participants was in keeping with the overall theoretical perspective of this research project.

Another possible way of selecting highly self-critical individuals could have been to have them self-selected. They might have responded to an advertisement requesting individuals who believed they were very self-critical to contact the researcher to participate in the study. Similarly, all the current therapy clients at the Clinic in the given year of the research could have been asked if they believed they were very self-critical, and if so, would they be willing to participate in a study about SC. However, a potential problem with both of these approaches is that a very self-critical person might not be aware of his/her self-critical tendencies. In fact, one participant confirmed that this was the case for him. He reported that he had been unaware of his own SC and how it was affecting his life until he had been in therapy for quite some time (over one year), and that when he realized it, that was a huge revelation. This was one of the reasons the DEQ was used to identify potential research participants. Before continuing to explain precisely how participants were chosen for this research, it is useful to consider just what the DEQ is.

The Depressive Experiences Questionnaire. (DEQ; Blatt, D'Afflitti & Quinlan, 1976; see Appendix 'D' for sample questions from the DEQ) – The DEQ is a 66-item self-report questionnaire designed to assess attitudes and feelings about oneself and one's interpersonal relationships. This scale measures personality traits that render an individual vulnerable to depression. Each item is rated on a seven-point Likert scale. It ranges from one (strongly agree) to seven (strongly disagree). The results are computer

scored and z-scores are provided for the three subscales; Dependency, Self-criticism, and Efficacy (see below). High scores on one subscale do not preclude high scores on either of the other two subscales. It is possible to use the DEQ more than once during therapy, such as at the beginning, middle and end. At the Education Clinic, clients completed the DEQ at Intake (usually their first appointment).

The items related to Dependency include being externally directed, concerned with abandonment, loneliness, rejection and the desire for closeness with others (Viglione, Clemmey & Camenzuli, 1990). Self-criticism items are more internally directed, with concerns around guilt, emptiness, hopelessness, insecurity, self-blame and feelings of personal failure. Efficacy "...describe(s) an individual with a sense of confidence in his or her own resources and capabilities, with high standards, and a conviction of being able to meet them" (Viglione et al., 1990, p. 54). In replicating the original psychometric properties of the DEQ, Zuroff, Quinlan and Blatt (1990) found high levels of internal consistency within the three subscales of the DEQ (Cronbach's alphas were >.93). They also found the three factors from their original sample correlated highly (>.77) with the replication college sample. The DEQ has been validated with both clinical (Riley & McCranie, 1990) and non-clinical (Shahar, Henrich, Blatt, Ryan & Little, 2003; Zuroff, Quinlan & Blatt, 1990) populations. Dependency and Self-Criticism have consistently been shown to be associated with higher levels of depressive symptoms, whereas efficacy "predicts decreased levels of symptoms as well as good psychosocial functioning and is thus conceptualized as a protective factor" (Shahar, Trower, Iqbal, Birchwood, Davidson & Chadwick, 2004, p. 481).

Scores on the DEQ are converted to z-scores. A z-score of 1.00 is one standard deviation above the norm. A score that high would be higher that 85% of individuals within the standardization sample. It is considered a high score on a particular factor. In order to ensure a fairly pure sample of self-critical participants, I selected individuals with a SC z-score rating of 1.00 or higher. I attempted to select participants with average or lower efficacy and dependency scale scores. I contacted potential participants to ask

them to participate in the research as long as their student-therapist had consented.

I was provided with information on the z-scores of new clients coming in to the clinic. Between 2004 and 2005, I kept a list of clients with DEQ-SC z-scores greater than 1.00. I started by contacting clients with the highest z-scores. For the eight (8) participants whose interviews I transcribed and analyzed, the range of DEQ-SC z-scores was from +1.11 to +2.42. Over half of the participants had a z-score of 1.49 or higher. The average was z = 1.66. The point of these numbers is simply to show this group of participants was a very self-critical group. This group of participants was also fairly low on the Dependency scale of the DEQ. Scores ranged from z = 0.69 to z = -1.68, with six participants having z-scores below 0.00. This suggests that overall, as a group, the participants in my research were more self-critical than the average person and average or lower in their dependency ratings. Scores on the Efficacy scale were not used in this research to aid in choosing potential participants.

Clients who contacted the Clinic primarily to receive career counselling and who had limited the focus of their counselling to that purpose (e.g., had five or fewer sessions) were screened out. Similarly, I did not contact and did not interview people who had already discontinued their counselling. All of the individuals I contacted and who subsequently participated in my research were actively involved in ongoing counselling at the time of our interviews. Some clients were very near termination due to the approaching end of the school year.

I phoned individuals I had identified as very self-critical, explained my research and asked if they would be willing to help with it. I explained that the purpose of this research was to explore and discuss the kinds of internal standards and internal dialogues people have and the kinds of self-evaluations people make, and how those things may be affecting the relationship between the client and the therapist. If they were willing to consider participation and agreed to hear more about the research, an initial meeting was arranged. Student clinicians were advised at this point

that I was planning to meet with their clients about my research and might be requesting a videotape of a session in the near future. At the initial meeting, I explained the purpose and process of my research in more detail to prospective participants, and answered any and all questions they had. The research was not specifically framed as being about "self-criticism," but in broader terms. After discussing this with my supervisor, this approach was decided on with the hope of avoiding any negative connotations that might be associated with the term "self-criticism." However, at the first meeting, participants were advised about the way in which they had been selected to be requested to participate in the research. Participants were also explicitly told about their right to refuse to participate in the research – for *any reason*, including if they did not view themselves as very self-critical.

Confidentiality. I also explained the way confidentiality would be maintained, as well as the limitations. For instance, they were made aware of the fact that while their therapist would know they were participating in my research because I would be obtaining a videotape from the therapist, the therapists would not be informed by me of anything that was discussed during the research interview. (See Appendix 'A': Client Information and Consent Form). Participants were advised that they were free to discuss any aspect of the research with their therapists or anyone else they chose, as the confidentiality clause applied only to me. This is important to note, because some participants expressed a desire or intention to discuss either the research or therapeutic issues that arose for them as a result of it, with their therapists. I wanted to make clear to them that they were entirely free to do so, but that I would absolutely maintain their confidentiality.

Potential participants were also advised of their right to decline to participate without fear of reprisal or penalty. There were a number of individuals who refused to participate for a variety of reasons. Some were uncomfortable with the idea of the interview and the IPR. Occasionally, time constraints were problematic (e.g., they did not have time to participate). A few had already terminated therapy when I called them. On at least one occasion, I observed a person's discomfort and hesitation in the initial

meeting, and took care to make extra clear that participation was voluntary and there would be no negative repercussions for declining to participate, including at that stage (or anywhere along the process). She declined participation at that point, and no further contact occurred with her. No participants opted out by the time they had reached the interview/IPR stage or later.

If the person was willing to proceed with the research, we arranged an interview at a time following the next scheduled therapy appointment. Generally, these interviews were scheduled either immediately after the session or within one or two days. The videotape that was used for review/IPR during the interview was always of the most recent session. This approach has both benefits and limitations. The benefit was that the session was still fresh in the participant's mind. There was no intervening influence of another session, which might have changed their experience of therapy or their relationship with their therapist since the session that they were watching in our interview. There were relatively fewer outside factors influencing their perceptions and experiences of therapy at that time – as opposed to all the various intervening influences that might be present if they were interviewed after therapy had terminated. That is, because the research interview was close in time to when they had the session being reviewed, there were not as many things in their lives outside of therapy that might have affected their perspective of that particular session.

One drawback to using a current session as opposed to an older one was that participants were aware during their counselling sessions, that they would be viewing the session later during the research. At least one participant mentioned that she had been more careful about what she had said during the session, because she was aware of the fact that we would be watching the tape in our interview. In a similar vein, one participant commented that she thought her therapist might have been somewhat more anxious and constrained during the session because s/he was aware of the fact that a tape of the session would be viewed by someone else, not the therapist or supervisor.

I did not think to ask each participant if s/he was aware during the session that it was being taped and would subsequently be used for our research interview. It would have been useful to know from each participant if s/he thought that knowing s/he would be watching the tape with me affected how s/he or the therapist had behaved. I did ask each person about how s/he was affected by participating in the research, and requested feedback from each one (more on that later).

Another drawback to conducting the research interview so soon after a session is that sometimes, it takes a while for clients to process what has occurred within a particular session. The initial response to the session, be it positive or negative, can change with time, as the client gains perspective and integrates the information or insights gleaned from the session into his/her everyday life. What initially seemed very meaningful sometimes comes to be seen as mundane and what was insignificant at the time later becomes a crucial aspect of therapy or life.

Demographic Information about Participants

There were eight individuals who participated in this research – five women and three men. Demographic information was not available for one participant because the file was missing. The participants ranged in age from 22 to 62 years. Four of them reported having a romantic/spousal partner, while the other four indicated being single. Five participants had some college or university education, and a sixth had a technological or trade certificate. In the Intake Package given each participant was a list of issues that might be the focus of therapy, and they were instructed to check off the ones they felt applied to them and that they wished to address. Participants checked off from 5 to 19 issues. Of the seven participants for whom there was information, all of them indicated that depression was one of the issues they wanted to address in therapy. The most commonly identified issues besides depression were Anxiety/Panic/Phobia (5 participants), Interpersonal Issues (5), and Assertiveness (5). There was a fair amount of variability in the number of sessions participants had, ranging

from 7 to 29 sessions. Six participants were working with a Master's level therapist; the other two were seen by students at the doctoral level.

Introduction to the Research Participants

This is just a brief introduction to each person. Each of these individuals was involved in counselling at the Education Clinic during the school terms between 2004 and 2005. Some people were still in the midst of their counselling, others were near the end. All of them had established relationships with their therapists.

"Paul"[13] was a young man in his twenties. He had not had a lot of counselling in the past. He was unique in that he did not seem to be aware of engaging in a lot of self-criticism – in sessions, in the interview or in his life generally. He also commented that while he thinks about what he is going to say, and chooses his words carefully, once it's said he doesn't worry about it. In our interview, I could not tell if he was editing his comments before he made them or if it simply took him a long time to formulate what he wanted to say. Paul had a total of ten therapy sessions. I interviewed him after his eighth session. Paul identified having academic, alcohol/drug, and interpersonal issues that he wanted to address in therapy[14].

"Sheila" was also in her twenties. This was her first experience in counselling. She told me it was not what she had expected; it was much better. She was anticipating someone being more critical and a therapist who was going to tell her what to do. She was surprised to find her therapist being supportive and helping her explore choices and options, instead. She was aware of being self-critical and perfectionistic, and noticed that at times, these qualities made it hard for others to be nice to her. There was no information available regarding the number of sessions Sheila had with her therapist.

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[13] The names of all the participants, as well as the names of their therapists, have been changed. Other identifying information has also been changed. In some instances, the gender of the therapist has also been changed to further disguise the participant.

[14] The issues identified for each participant are *in addition to* depression. That is, all seven for whom information was available identified depression as an issue to address.

"Amber" was a young college student who was struggling to come to terms with the death of a significant family member. It seemed to me that her self-critical tendencies might have become more pronounced and problematic during her grieving. Amber was aware that she tries to be perfect and does not like anyone to see her 'down.' She observed that things had been improving for her, but worried that it would all come crashing down. There was a certain vulnerability to her presentation during our interview. I think in other contexts she probably did make sure to appear 'together' and to hide her struggles and pain from others. Amber had seven sessions with her therapist, and this writer interviewed her after the last session. Amber was addressing academic, grief/loss, perfectionism, and stress management issues with her therapist.

"Arlene" advised me she had had many years of counselling. While she clearly wished she had not had the need for so much counselling, her interview had a depth and her comments a wisdom that came from all this experience. She shared that she thought her years of therapy had helped her have more clear goals and more determination to work on them. She said something that I will never forget: she wished there was a self-help book for people to learn how to handle happiness. Arlene came across as a strong and powerful person, so when she shared moments of vulnerability or revealed painful emotions, it was unexpected and potent. It would have been hard to be unmoved by her in those moments. Arlene was very articulate and insightful. She knew herself well and was also an astute observer during the interview process. Arlene completed 24 therapy sessions, and had had 12 when she participated in this research. Arlene's identified issues ranged from academic and work issues to interpersonal relationship issues to anxiety, body image and grief/loss. However, in our interview, she revealed her primary focus was related to work.

"Debora" was a sparkling woman who had a tenderness about her. Like Arlene, Debora had a lot of experience in therapy. She provided insights into helpful and unhelpful, even harmful, therapist qualities and actions. Debora shared that she found the experience of participating in this

research, specifically watching the tape of her session, assisted her in developing a new kind of empathy for herself. Debora struck me as the kind of person who could tell a tragic story in a way that made you laugh until you had tears in your eyes. At the same time, I can still vividly recall the harshly critical things she told me she would often say to herself. She seemed strong and capable, and yet somehow an urge to protect her arose in me during our interview. Debora identified having many issues ranging from anxiety to interpersonal issues, from body image to perfectionism. I interviewed Debora after her 16th session. She continued on for another 13 sessions (29 total).

"Nathan" was a young man who seemed the most uncomfortable of any research participant during our interview. He told me months later he believed part of why he agreed to be involved in the research was to punish himself, because he was doing something good for himself by coming to therapy. In our follow-up interview, I had the opportunity to hear about the progress he had made in therapy since our initial interview. Despite finding having to change therapists disruptive and difficult, he spoke of his therapy experiences very positively. It was wonderful to see the change in Nathan over time. The year I interviewed him, Nathan had 19 sessions. We met for our research interview after his 12th session. He identified such issues as anxiety, grief/loss, self-esteem, stress management and interpersonal issues as problems he was hoping to address in therapy.

"Ishmael" shared that he came to the Clinic for counselling because he could not afford to continue seeing his other therapist. He advised me he was looking for a therapist who could be "almost aggressive" with him. He did not want to "dilly-dally" in therapy, and did not feel he could accomplish what he wanted to if his therapist was too soft with him. He often illustrated the meaning of his words with vignettes about himself and his life experiences. Despite reporting being depressed and in physical pain, Ishmael had a vibrancy and artistic sensibility about him that was inescapable. When he told the stories about himself, emotions filled his voice and his demeanor was animated. I knew he was not exaggerating when he

told me people often invite him to their parties because he is entertaining. He also seemed to be honest about his own foibles and shortcomings. Ishmael was only able to get in nine sessions before the end of the term, although he would have preferred more. We met for our interview after his sixth session. He identified multiple issues such as abuse, anger management, childhood trauma and interpersonal issues.

"Jenna" was the final person who participated in my research project. She was one participant who spoke clearly about the difficulties the limitations on her therapy (e.g., running out of time, having to stop and find a new therapist) were creating for her. She shared some of her previous experiences in counselling, both positive and negative. Jenna was one participant who also talked about barriers that were created for her by having a male therapist. She advocated strongly that videotape review – with one's regular therapist – should be a normal part of therapy, because she had found that part of this research very beneficial. Jenna also revealed having very conflicting feelings about participating in her research interview. She mentioned several times that she really would have rather been outside enjoying the lovely day. Still, she spoke very enthusiastically about the benefits of having participated. Her reluctance was known, yet it did not seem to make her participate with any less thoughtfulness or consideration for the process. Jenna had a total of 17 sessions. The research interview occurred after her 16th session. She also identified multiple issues including anxiety, assertiveness, marital/relationship problems, and feelings of guilt.

Procedures

Interview Strategies

When I met with each participant, I conducted the interviews in three segments. I began by eliciting general comments from participants about their experiences in therapy, their relationship with their therapist and their overall impression of the helpfulness of therapy thus far. Secondly, I employed IPR to review the tape with the client and discuss what was happening for them during that particular therapy session. Lastly, I asked some relatively direct questions about how self-critical they perceive

themselves to be and how this might have been impacting their therapeutic experiences, their relationship with their therapist or their relationships with others. In the next few pages, I will lay out some of the rationale and procedures for these techniques, beginning with the interview.

I utilized semi-structured interviews, along with Interpersonal Process Recall. I developed a set of questions (see Appendix C) that I referred to, to guide the interview process. I worked to guide but not limit the discussion. I wanted to leave enough latitude for the participant to discuss whatever s/he felt was relevant to the topic. I began with a review of the purpose of the research and a description of what I envisioned would happen during our time together. Participants were given the opportunity to ask any questions they had at the outset and were advised they could ask questions at any time along the way. I initiated the interview process with several general questions. This provided opportunity to develop some rapport with participants and opened the way to watching the videotape. I also explained at that time that each participant was welcome to stop the tape at any time to discuss what was happening or her/his reaction to some exchange with the therapist.

Kagan and Kagan (1991) suggest that people have a wealth of knowledge about their interactions with others that they ordinarily do not acknowledge. This they believe is true both in general and specifically with regard to what is occurring in therapy sessions. One effective way to tap into this wealth of knowledge is through the use of in-depth interviews. Elliott (1986) reported that he and his colleagues found that "clients' qualitative descriptions of significant events... offered a rich source of information about the change process" occurring in psychotherapy (p. 507). The role of the inquirer, or interviewer, is to facilitate the participant's explicit discussion of what they know but have not yet verbalized about their own experience or what is happening during therapy (Kagan & Kagan, 1991).

Osborne (1990) recommends the use of open-ended, minimally structured interviews to obtain the richest data from participants. Merriam (2002) suggests a semi-structured format can be effective for qualitative

research interviews. By having some structure, the interviewer ensures that certain relevant topics are covered. However, leaving room for open-ended discussions creates enough latitude in the interview for participants to introduce material they feel is germane and has not been brought up by the inquirer. It allows for the interviewer to follow the flow of the interview more, rather than interrupting the process or conversation to direct the participant to a new question.

Interpersonal Process Recall. (IPR) I followed the procedures commonly used for IPR, which are described here. IPR is an interview and videotape review technique that involves having some aspect of performance or some type of behaviour videotaped (in this case, psychotherapy sessions), and reviewing the tape with one or more of the persons involved in the action, in order to discuss in greater depth what was happening (physically, mentally, and/or affectively) during the taping. It is generally conducted in a number of steps (Bernard, 1989; Elliott, 1986, 2000; Elliott, Barker, Caskey & Pistrang, 1982; Kagan & Kagan, 1991; Kagan & Kagan, 1997; Rennie, 1990; Wiseman, 1992). First, a psychotherapy session is videotaped. In some instances, the videotape is reviewed immediately with the client (that was not possible in this research). In other cases, it is reviewed within 48 hours of the session occurring.

Together with the IPR interviewer-researcher, the client watches the videotape. Some researchers have given client-participants structured questionnaires about various aspects of therapy or their therapist to complete during this time (Elliott, 1986). Others have allowed participants to control the play of the videotape, stopping to comment whenever they feel something significant transpired or when they were aware of some important internal process that affected what subsequently occurred in therapy (Kagan & Kagan, 1991). The interviewer may ask questions of the participants to encourage elaboration of a comment. Kagan and Kagan (1997) described the interviewer as an *inquirer*, whose purpose is to facilitate the participant's description of underlying thoughts and feelings, rather than self confrontation.

These conversations about the therapy session are audio- and/or videotaped for later transcription and analysis of the data. If videotapes are made of the IPR sessions, information about participant behaviour can also be incorporated into the transcription and data analysis process. With more structured responses, data have been analyzed using content analysis (Elliott, 1986). With unstructured interview formats, other qualitative analyses have been utilized.

My decisions about which parts of the tape I discussed with participants were related to both the content and process of the specific psychotherapy session. For example, what a client said as well as body language and nonverbal communication guided me in deciding which portions of the tape to ask about or discuss. Client-participants were encouraged to choose relevant moments on the tape and to stop the tape to discuss what was happening for them or their thoughts, feelings or subsequent actions. The questions I brought to the interview served as a guide to ensure relevant topics were covered during the interview. Both the participants and I were able to stop the tape to make comments. I did not watch the tapes of therapy sessions prior to meeting with the participants, because this had not been explicitly negotiated with them at the outset. I chose not to ask that of participants because I did not want to add to their discomfort. While the reaction to the IPR process was generally positive *during and after* the interviews, participants certainly did not appear excited about the prospect beforehand. Furthermore, some of them expressed relief when I advised them I would not watch the tape before the interview.

There are a number of important reasons for choosing IPR to study what is happening during the therapy hour (Elliott, 1986). The use of videotape to stimulate recall is a much more powerful method than simply relying on the free recall of the client, particularly when one is interested in a specific event. Memories often tend to become integrated and organized into a coherent whole, so that an individual's free recall of specific moments in therapy is different and less detailed than what can be accessed with aid of videotapes. These integrated memories are no less valid, meaningful or

important; they may be less accurate about what an individual was experiencing, thinking or feeling during a specific moment in a particular therapy session. Integrated and composite memories are no less interesting or important from a research perspective. I have, however, chosen to focus more on the actual specifics of a particular session that each client/participant will have recently gone through. It was hoped that by reviewing the moment-by-moment experiences in therapy, more could be understood about how self-criticism affects what is happening during therapy. The intent was to find out more about if, how, and when SC was occurring within therapy.

Because IPR is generally completed within 48 hours of the therapy session occurring, the experiences are very recent, and fresh in the client's memory. Furthermore, IPR is especially effective for researching psychotherapy from the client's perspective, because the individual has the interview with someone who can be perceived as a neutral third party. Elliott (1986), Rhodes, Hill, Thompson and Elliott (1994), and Rennie (1994, 2000) have noted that clients often do not disclose all of what is going on for them in therapy, particularly negative reactions they may be having to the therapist or the therapy process (see also Safran, Muran, Samstag & Stevens, 2001).

These researchers have found that clients are often far more open about their experiences of the process of psychotherapy with their IPR interviewer/ researcher than they were with their psychotherapist. This makes IPR particularly appealing as a research tool for examining what highly self-critical clients are thinking, feeling and experiencing in therapy. Both Elliott (1986) and Kagan and Kagan (1991) reported that individuals had much more awareness of their interactions than their outward behaviour would imply. Safran et al (2001) noted that clients are often unlikely to share negative reactions to therapy or their therapist, and therapists are somewhat unlikely to detect these reactions without feedback from their clients.

With the aid of videotapes to help recall specific moments in therapy, clients could very well speak meaningfully about thoughts, feelings and processes in therapy that were related to or impacted by self-criticism. The video is an objective marker for the participant; one that both triggers memories of the therapy session and constrains the interpretive and integrative aspects of memory.

Pilot IPR. In order to be better prepared for using IPR with clients from the Education Clinic, and to get the most out of the process and the interviews, I conducted a pilot IPR session. In February 2004, I met an individual, "Lauren" who was attending counselling in the community. After finding out about my research topic, she expressed an interest in participating in my research. We had several discussions regarding the nature of the pilot project, what she might expect, and my reasons for attempting such an endeavor. She discussed my pilot project with her therapist, who graciously consented to allow the therapy session to be videotaped and reviewed by her client and me. Lauren provided the appropriately modified 'Consent to Participate in Research' form to her therapist. She taped a session and brought it to the Pilot Interview/IPR. That was conducted in my home. She took her tape home with her, so in that way, confidentiality was maintained.

This pilot project gave me an opportunity to practice using the IPR method of reviewing tape and discussing what happened during the session. I had the chance to try out some different kinds of questions and approaches to the process, as well as hear from Lauren what she thought, felt and experienced during the session. She provided valuable feedback and insight about the process. Her comments helped me generate and refine some of my interview questions and techniques.

There were several issues that came up during this practice interview/IPR that foreshadowed my findings in my formal research project. As we watched the video, Lauren talked about the fear and vulnerability she was feeling while revealing information about herself to her therapist. I wrote in my journal, "She was constantly on the lookout for moments when

her therapist might be judging her or negatively reacting to her comments." I went on to write, "Similarly, I think trust was an issue. She was quite afraid to speak to her therapist about things she didn't agree with (e.g., the direction of the session) or even just the content of the session (what she would say), even though in the past, her therapist had responded positively to comments she had made. So, it's not based on recent past experiences with the therapist, but previous past experiences that pre-date the relationship with the therapist." The reader will find that these experiences parallel what some of my later research participants shared with me in their interviews.

In general, I found the interviews changed from the use of IPR. Self-critical processes and tendencies became more apparent when we started watching and discussing the tape of the therapy session. Participants' comments about what they experienced in therapy became much more detailed during the IPR than the general comments they had made earlier about their therapy. As such, IPR was a crucial component of this research; it was a necessary aspect for learning what I did regarding self-criticism.

The Interviews

As stated above, each interview had three different parts to it. In the first part, the process was explained, and I asked the participant general questions about his/her therapy experiences. It was initially my intention to find out about the participant's relationship with his/her current therapist. However, over time, it became clear that most participants had been in therapy before and had experiences with previous therapists that they were willing to discuss. As a result, I began to invite participants to talk about experiences with previous therapists, if they chose to. They were invited to talk about both helpful and unhelpful experiences in therapy, past and present. In this way, I discovered that most of my research participants had been in therapy at least once before. One advantage of using a qualitative approach to data gathering is that the researcher can respond to emerging situations. I was able to respond and change part of the process of data collection based on what I was learning and experiencing in my interviews.

IPR occurred in the second phase of the interview. We turned our attention to the videotape of the session. I explained what I would be doing – stopping and asking questions about particular moments in therapy, asking for information about what they might have been thinking, feeling, remembering, etc., in a given moment or how they were impacted by their therapist at a particular time. I also invited the participants to feel free to stop the tape at any time to make comments about what had been happening in the session or what they were thinking, feeling or experiencing now while watching it.

In the third phase, the tape was turned off and the participant was asked for final comments about their therapy. A few more questions regarding the participant's relationship with his/her therapist were asked. The participant was then invited to provide this researcher with feedback about the experience of participation in research. Positive and negative aspects were explored and suggestions for improvement were solicited from participants. At the close of the interview, I explained the rest of the research process. I advised each participant that I would be transcribing the interviews. Once this was complete, I would be contacting each one to send a copy of the transcribed interview, along with my beginning analyses. I let each person know that I would be asking if s/he wanted to make any changes, additions or deletions to the interview. Feedback was also welcome about my early analyses. At this point, participants gave me contact information where they believed they would be able to be reached for follow-up. The interviews ranged from one-and-a-half to three hours in length, with seven of them lasting at least two hours.

Technical Difficulties

Lost Interviews. On April 28, 2004, I had completed eight interviews of research participants. Unfortunately, due to technical difficulties, only three (3) of these initial interviews had adequate sound quality to be useable. A lamentable decision I made was to make only one tape of each interview, so there was not a second tape that I could turn to when I could not understand the interview on the first tape. The difficulties with the recordings

seemed to coincide with the change from a battery-powered cassette player to an electrically powered one. It turned out that the adapter that I was using had multiple settings, and I had it set to the wrong one!

Unless you have been through this yourself, it is difficult to imagine my dismay and growing horror as I played the last five interviews and realized I could not possibly make out what was being said. It seemed impossible to believe. Before each interview, I had gone through the "Testing, Testing, 1, 2, 3," rewound the tape and clearly heard my own voice repeating that phrase back to me. The sad fact is that after ascertaining that I had useable interviews with the first three recordings, I felt safe to trust that if I followed the same steps for the rest of the interviews, I would have no problems. Now I realized with a perfect clarity why some researchers make as many as *three recordings* of each interview!

I had hopes of salvaging the tapes and set out to see if a recording studio might be able to assist me in this endeavour. Alas, it was not to be. In July 2004, I visited a recording studio in the city that helps police officers "clean up" poor quality tapes made of suspected criminals. They were not able to help me. I spent another afternoon with a very kind man who worked hard to see if he could get rid of the fierce humming that drowned out the voices on the tapes. With a great deal of effort, he nearly cleaned up about 30 seconds of tape. He determined that the problem was some kind of electrical humming. However, it occurred at random, rather than consistent intervals, and so could not readily be removed from the recordings. Finally I had to face the fact that over half of my initial interviews were unusable. There was nothing else to do but get approval to conduct more interviews the coming school year.

Generally, it seems from my journaling that the same kinds of things were happening in the interviews I was unable to transcribe. There was evidence of SC and perfectionism. One of these participants gave me the idea that perhaps sometimes ongoing internal evaluation keeps individuals from being fully present during their therapy, as well as in other contexts. There were several interviews where I felt I had not gotten at what I really

was looking for, although there was at least one where I felt so strongly that I had *finally* really heard about someone's self-criticism. However, upon reflection, I felt affirmed that I did indeed get better data in the second set of interviews.

The Second Set of Interviews. The second interviews were conducted with the same three essential phases as the first ones. Research participants were contacted in the same way, and student clinicians' consents were obtained the same way, as well. Naturally I approached the recordings of said interviews with a great deal of trepidation. I made two recordings of each interview. I made sure I checked both tapes after each interview, to ensure I would be able to transcribe them later on. The second set of interviews was a resounding success. I improved my questioning and exploring with participants and in my opinion, improved the quality of my data.

When the second set of interviews was completed, I set about transcribing them. This proceeded without any significant setbacks. As I transcribed the interviews, I made notes about them in a 'Memo' column I had created expressly for that purpose. Even at this stage, some themes were beginning to emerge. Commonalities between interviews were becoming apparent, and I noted these and wrote about them in my 'Memo' columns and Dissertation Journal. Once I had transcribed all eight interviews, I read through each one and highlighted quotes that I thought related meaningfully to my research question. I made more notes in the "Memo" columns.

Follow-Up Efforts

At about this time, I also began attempting to contact each of the research participants to send them a copy of the transcribed interview. Two of my research participants ("Paul" and "Ishmael") I was not able to contact at all. The telephone numbers I had for them were either no longer in use or were no longer their numbers. I sent Ishmael a copy of his interview via registered mail. It was returned to me, with a note from the Post Office that he had moved, new address unknown. I did not have Paul's address.

I was able to contact the other six participants and either mail or e-mail them a copy of their interview along with my beginning analyses. Of these, I was unable to reach three of the participants ("Debora," "Amber," and "Jenna") to obtain any feedback or responses to copies of their interviews. I made telephone calls and sent emails to the email addresses they had given me without receiving any response. This was unfortunate, as I had hoped to at least confirm with them that they had received, read and continued to agree with the content of their original interviews. After receiving a copy of her interview by mail, "Sheila" called and advised me she agreed with the contents and had no further comments to make. She also requested I help her obtain a referral to the Clinic for further counselling, which I did facilitate.

"Arlene" and "Nathan" both agreed to a follow-up in-person meeting. These meetings were extremely helpful and provided new insights and information about my research. Both have expressed a willingness to continue to be contacted and an interest in seeing the final document when it is completed. Their comments have been integrated into Chapter Four. In her follow-up interview, Arlene clarified what she had meant when she spoke about "tolerating happiness" and "performing" in session (these are described further in Chapter 4). She explained more about the situation that led to her loss of trust in her long-term therapist. We also discussed the impact of limiting the number of sessions can have, what "rank" means to her, and how she had been looking for warmth in her therapeutic relationship even though she kept her therapist at a distance from her.

The follow-up interview with Nathan was very valuable to my research. It provided further information that confirmed some of my hypotheses. He shared how it had been his "inner bully" that had prompted him to participate in the research. I was fascinated to find out that it was only when he had read the transcript of his interview for the second time that he became consciously aware of that. He told me he found that reading the transcript of his interview, along with my beginning analyses and comments about similarities between interviews helped normalize some of

his experiences for him. In my journal, I wrote, "He went on to say it took about six months of therapy to really realize that he was self-critical, and that it was a genuine problem for him. He said when it happened, 'it wasn't a little thing. It was a revelation!'" He strongly agreed with my analyses when I had written he seemed to be judging himself. He also shared that he was aware that some of his perceptions were skewed. This was important because not many other participants expressed the notion that their perceptions may have been inaccurate. One outcome of this follow-up interview was how obvious it was that providing him with the opportunity to continue in therapy (although he'd had to change therapists twice) had been very beneficial for Nathan. It strengthened my belief in my findings that a serious impediment to progress for very self-critical people can be limitations on the amount of therapy they can have.

Lastly, Nathan provided me a very vivid example of how difficult it can be for someone who is very self-critical to receive positive feedback. In my 'Memo' column, I had noted while transcribing that while he had said he was a 'mostly uncomfortable person,' I was finding him more and more likeable while I was transcribing. He pointed this out in our interview, and said he did not usually think of himself as a likeable person. When I reaffirmed my experience of him, as well as expressed my gratitude to him and my other participants, he became visibly uncomfortable. His hands were shaking and he was wringing them. The last sentence in that journal entry read, "Anyway, I told him I didn't want to make him uncomfortable by giving him that positive feedback, and suggested he just put aside my comments for the present and come back to them later on."

Analysis of the Interviews

Basic Interpretive Qualitative Analysis. As discussed above, I conducted a basic interpretive and descriptive analysis of the interview and IPR data I collect. I utilized Thematic Analysis (TA – described below). Once I developed clusters of meaning units, I analyzed and reflected on the possible themes or patterns that these clusters reflect. This was a recursive procedure of gradual refinement. I took efforts to notice and continue to

attend to exceptions and individual differences during this process. Merriam (2002) asserts it is important to seek out disconfirming evidence and to take that into account during one's qualitative analysis. These clusters of themes were given descriptive labels, which were progressively refined so they captured the meanings and experiences contained within. Along this process, exemplars were chosen from the interview protocols, to vividly portray each theme to the reader.

The themes that were developed were organized into higher-order themes. Themes that were related or reflected similar kinds of experiences or processes were grouped together and given overarching descriptive labels. Sometimes researchers choose a single, final overarching theme under which all the other themes fall. In the end, I had two overarching themes under which all of the data could be subsumed.

Use of a Computer Data Analysis Program. I made the decision to use a computer software program to aid in the analysis process. The program I chose to use is Atlas.ti. The creators of Atlas.ti introduce it thus,

> ATLAS.ti is a powerful workbench for the qualitative analysis of large bodies of textual, graphical, audio, and video data. It offers a variety of tools for accomplishing the tasks associated with any systematic approach to unstructured data, e.g., data that cannot be meaningfully analyzed by formal, statistical approaches. In the course of such a *qualitative analysis*, ATLAS.ti helps you to explore the complex phenomena hidden in your data. For coping with the inherent complexity of the tasks and the data, ATLAS.ti offers a powerful and intuitive environment that keeps you focused on the analyzed materials. It offers tools to manage, extract, compare, explore, and reassemble meaningful pieces from large amounts of data in creative, flexible, yet systematic ways (Muhr, 2004, from the Introduction page of the Help Menu, http://www.atlasti.com).

Each of the interviews was entered into Atlas.ti (described above), a qualitative data analysis computer program. The quotes I had previously selected when reading the transcripts were tagged and given some kind of descriptive label. While completing this process, I re-read the interviews and added new quotes, deleted ones I now considered irrelevant and added memos. Quotes that were related to the same phenomenon were given the same descriptive label, thus creating a code. I put codes that related to similar phenomena into categories. For example, the Category "Feeling Misunderstood" included such codes as "Digging for Nothing" and "Not Feeling Heard."

Using Atlas.ti, these categories were organized into themes. Using the above example, "Feeling Misunderstood" fit into the theme, "Interpersonal Issues: How do Others See Me?" Once all of the interviews were coded, I began attempting to identify themes and commonalities. When this was done and I had found a theme for every code, I began exploring ways to organize the data into higher order themes. At one point, after struggling to find a pattern and meaning within the data, and after a discussion with my supervisor, I decided to essentially "scrap" my initial analyses and begin again. Somehow I had not satisfactorily captured what was revealed in the interviews.

Using a constant comparative approach, I looked at each of the categories and codes, and I examined all the quotes again, to ensure each of these still constituted a cohesive group. There were multiple levels at which to repeat this process. When all of the categories had been satisfactorily identified, several attempts were made to organize these into themes. Fairly early in this process, it became obvious to me that all of the data would fit neatly into three clearly delineated sections: a) findings about SC and potential ways it could interfere with therapeutic progress, b) findings that revealed ways in which therapists and clients make therapy more effective, and c) findings that related directly to the experience of participation in this research. However, the information was too large, broad and diverse to leave in these three overarching themes alone.

With that in mind, I set about discovering the categories and themes various codes might be assembled into. This entire process was reflexive in that at each stage, the analysis would lead me back into all of the earlier stages, as far as the very interviews themselves. Quotes and codes were considered in context of the original interviews to ensure I had stayed faithful in my analysis to what the participants were telling me. I also repeatedly looked across interviews to identify similar patterns as well as noticing differences. This helped to ensure that codes, categories and themes remained cohesive. Finally, this process was mostly complete. I made some minor changes during the write-up of the findings.

None-the-less, I felt comfortable with the results. I felt that the most important findings remained in clear view, and that other findings supported, added to and clarified these major findings. I believed that what the participants had shared with me remained visible and comprehensible. With that complete, I turned my attention to the actual writing up of the results. In the coming pages (Chapter 4), I will review in detail my findings. After that (Chapter 5), I will discuss my interpretations of my findings.

"And recalling all the cruel words he had uttered, Anna invented other words which he evidently had wished to say and could have said to her, and she grew more and more exasperated. ...
All the cruelest words that a coarse man could say he, in her imagination, said to her, and she did not forgive him for them any more than if he had really said them. ..."

"Anna Karenina," Tolstoy, 1878, published by Wordsworth Editions Limited, 1995, p. 739

CHAPTER FOUR
FINDINGS

This chapter is dedicated to explicating what was learned from the participants during their interviews. The findings fit into one of two overarching themes. The first I have termed "Road Blocks: Ways Self-Criticism Interferes with Progress in Therapy." The first roadblock is the Self-Critical Approach to Life, and it reveals how participants were engaging in evaluation and had a negative outlook on life. The second roadblock is the Self-Critical Approach to Relationships. This roadblock shows how concerns about rejection and judgment affect participation in therapy. Fear, shame and coping by avoiding problems also stood out as factors that interfered with the therapeutic process. It also became apparent that time pressures and limitations on therapy negatively affected participants in this research.

The second overarching theme I have termed, "Bridges: Opening the Roads to Change." There are two main ways the road to positive change is opened: first, through therapy and the person of the therapist; second through the client and his/her actions. When we have made our way through these two main themes and all that is contained within them, I will turn to what I found and what participants shared about the experience of participating in this research study.

FINDINGS

I. Road Blocks: Ways Self-Criticism Interferes with Therapeutic Progress

There were a number of roadblocks to therapeutic progress that I uncovered in the analysis of the participants' interviews. Broadly, they can be thought of as falling into one of three areas: having a self-critical outlook on life, having a self-critical approach to relationships, and the effects of time limitations on therapy.

A. The Self-Critical Approach to Life

The participants' approach to life seemed to mirror what has often been noted regarding self-critical people in general. Like others who have been researched, the participants seemed to be nearly constantly engaged in

some type of evaluation – be it of self or others. Nearly every thought or action might get evaluated, rated on its merits, worth or goodness. It had the potential to interfere with involvement in and enjoyment of almost anything the participants did. Another frequent mental activity noted was criticizing. Criticizing is closely related to evaluation. Not only is the phenomenon evaluated, but is usually given a negative rating, a "failing grade." This seemed to be most often directed toward the self, but was also sometimes directed at others. These phenomena will be described below in more detail and illuminated with the words of participants.

1. Engaging in Evaluation

In this section, I will highlight some of the evaluative and critical comments participants made during our research journey. They made themselves the most frequent targets of their evaluation and criticism. Not all evaluation was negative and critical. Occasionally, it was actually helpful. Often they were aware of having high expectations, but did not see them as being unreasonable or unattainable. Sometimes they held their very high standards up to others, including their therapists.

Ongoing Evaluation/Scrutiny. Throughout my research interviews, participants engaged in ongoing evaluation and scrutiny of themselves. Within the research interviews, the evaluation tended to be directed towards their words and actions in session. As they watched themselves on tape during the IPR portion of the research interviews, they evaluated what they said to their therapists, and how they said it. They criticized their appearance and mannerisms. They considered how well they had used their therapy time.

Ishmael evaluated both how he acted in session and how he handled his therapeutic homework assignments. He worried that he might be playing games with himself and/or his therapist:

> and I think I do things – I mean I know I do things intentionally. Okay? But, what happens is – in the critical part of this, is that I find – see this is where the game-playing aspect comes in. And this is where I'm afraid, I don't want to get caught... I don't

> want to subvert myself. Um, um, in playing a chess game..... in that, I already know, (laugh) I already know about myself and my foibles, and whatever. And so I can ask a question to make it look good or bad. Um, or to rationalize or whatever. You know what I'm saying?

Debora and Paul evaluated whether or not they were avoiding issues in therapy. The answer seems somewhat obvious, since they both indicated having things they felt they needed to work on that they had not told their therapists about, but it was also a more minute evaluation. That is, they were wondering not only 'am I avoiding something' in general, but 'am I avoiding something right now?'

Debora commented "Um, it's so crazy because it's like I can't you know, help myself. Um, I just, it's so much easier to 'chat' than to talk about your problems." Paul questioned, "Now I'm kind of, at this point, did I really get the issue or was I just kind of... trying to ... uh, trying to talk my way out of it, or you know?" Other participants also evaluated what they said and how they said it in therapy. One person evaluated his hand gestures and voice quality while watching the tape of his therapy session.

Participants also evaluated themselves and their readiness to address particular issues. Debora noted, "It's because like, it's obviously such a huge problem, and I didn't bring it up, because um, (sigh) because people - because first of all, people tend to think one should work on that problem, and I don't know that I'm 100% ready to work on it right now. And that's hard to admit." When I coded these quotes from the research interviews, I labeled them "Client pacing self." I view this self-pacing as essentially positive and adaptive on the part of clients. However, mixed in with that was something of a tendency to be disappointed in oneself, as Debora was because she was not ready to deal with a particular issue in therapy.

Participants evaluated their relationship with their therapist. I did ask participants what they thought of their relationship with their therapist, so that brought out evaluative comments. However, some of them had also thought of it before being asked. For instance, Nathan had considered

whether or not he saw his therapist as an authority figure or if they were basically equals, and had decided they were equals. Arlene told me she struggled with not dismissing what her therapist had to say because she knew he was a novice. She evaluated him as a "lesser being" in some ways, because of that. Ishmael evaluated his therapist's ability, and felt his need of help was greater than her ability to help him.

Participants evaluated whether or not they were making enough progress in therapy, whether or not they were wasting time in therapy, whether they were dealing with the 'real issue' or not, and they evaluated their therapists' responses to them. Debora, for instance, observed,

> ...I think the therapy that I've been receiving has been sort of like, wherever I want to take it is where we go. And I think in some ways that's really excellent, and maybe it would drive me crazy to have anything else. But in some ways, I sometimes think, well, there may be something I'm avoiding that (pause) maybe Fabian (her therapist) knows something I don't know. You know?

There were times when participants identified that they also tended to evaluate others. Arlene had this to say about evaluating, "Why am I evaluating this? Am I trying to get away from something here? Um, because you know, evaluating someone else is a good way to shut them down and then you can ignore them. Right?" She also shared that "if I assess or I judge that I'm not getting enough in that friendship and I'm giving more than I'm getting, then it'll directly influence my behaviour and my choices. Um, rather than discuss it with them, I'll be behaving in a different way. And the same can be said on the job." She reflected that prior to our research interview, she had not really considered how damaging that evaluation was to her relationships with others.

Being Self-Critical. Not surprisingly, I noticed evidence of self-criticism in the participants. I have differentiated being self-critical from general evaluation to denote the distinctly negative, critical aspects that go beyond evaluation. Hypothetically, one could evaluate oneself without necessarily

being critical. If a person's standards were not unreasonably high, she might engage in constant evaluation, assess that she is meeting her goals and expectations and feel satisfied with herself. To be critical here, means adding the dimension of negativity. The person evaluates himself, decides he has not measured up, and is critical of himself, as a result.

It seemed likely that for some participants, their inner criticizing developed historically from ongoing criticism they received from others, especially their parents. Ishmael indicated having his abilities and accomplishments dismissed and devalued at times by his parents. Sheila shared that as a girl growing up, she was constantly quizzed by her mother about how much work she had accomplished and why more had not been done. Having impossibly high expectations of herself seemed to mirror these early experiences.

Most if not all the participants engaged in some kind of self-criticism at various points during the research interviews. While there was not always direct evidence that they were engaging in self-criticism during their sessions, comments they made to me indicated they were being self-critical, both in session and afterward. I have identified self-blame as evidence of inner criticizing by the participants. Debora and Jenna mentioned their tendency to blame themselves when anything goes wrong, including in therapy. Debora put it this way, "...I can see that it's unhealthy to believe that it's somehow my fault, or that I'm doing something wrong, but I do none-the-less tend to believe that."

For Jenna, "I guess, my biggest thing is I take responsibility for things that aren't my fault. ... Strangely enough, I think when you're self-critical, I think you take blame. You take, you think, if I would have only done this differently then that would have happened differently, right? You take a lot of those responsibilities or the thinking that if I wouldn't have spoken about that, then, you know, maybe this would have been different." Jenna also identified having a tendency to "rehash" things, and to engage in recriminations after the fact. She expressed the belief that these recriminations kept her from forgiving and forgetting it, and moving forward, leaving the past behind.

Nathan's ongoing inner criticizing was apparent during our interview. He was critical of himself and his behaviour during his therapy session, and he was critical of what was happening in our interview: "But it's - it's logical brain vs. emotional brain, ...it's the little voice in the back of my head going, you're being dumb, you should not be here, this is - and logical brain going, yes, this is exactly why you're here." He indicated that at times, that inner criticizing was helpful in therapy, as it helped him keep himself 'on track.' He shared that he was actually less self-critical during therapy than in other contexts. In our follow-up interview, he told me that saying those critical inner thoughts out loud in session helped him be able to stop the self-criticism and its negative effects on him. (This will be discussed in more detail later on.)

Paul wondered at the beginning of our research interview if we would find evidence of what I was looking for (Self-Criticism) in his therapy and identified himself as only "slightly" self-critical: "I mean it happens occasionally, where I walk out of a situation, and kind of think, like, 'what was I doing? Why did I do that?' Or you know, something of that nature." None-the-less, during the IPR portion of his interview, Paul made several comments criticizing himself and what he had said in his therapy session. "I keep thinking of other ways that I could have kind of said things... well, I said this, and this, and this, and this, and I coulda just said this. And it would have settled it completely." However, most other participants readily identified themselves as self-critical, at least some of the time.

Ishmael observed that he is constantly engaged in criticizing and critiquing himself. When asked if he thought his criticism was helping or hindering him more, he said, "It's hindering me more, because I find myself talking to myself and always chastising myself." His ongoing evaluations were leading him to rebuke himself, rather than just motivating him to notice or strive to do better.

Hampered by (Unreasonably) High Expectations. Several of the individuals I interviewed acknowledged their not only high expectations, but perfectionistic tendencies. Amber said, "Like I guess, like I do try to be

perfect, and I do try to do all this stuff. And when I – I'm very hard on myself." Arlene acknowledged both having perfectionist tendencies and a "fear of success because success demands more performance for you." Ishmael described his perfectionism as a "striving for approval."

Participants in my research revealed that they often had very high, sometimes unreasonable expectations for themselves. Having unrealistically high goals and expectations for themselves contributed to participants not enjoying or appreciating the progress they had made or were making in therapy.

Sheila provided a sparkling clear example of not recognizing progress. She recounted how a recurring problem in her relationships with family members had led her to tell her partner she thought therapy was not working.

> ...15 minutes later or something, I was sitting on the couch reading or something. And he was like, ya see? If you hadn't gone to therapy, you wouldn't have mellowed out. You would have still been (upset) for the next hour. And I was like, well that's not true. He's like, look. You're cool as a cucumber now. I was like, Huh. I am, aren't I? Maybe it is working.

When Amber's therapist gave her feedback (seen during the IPR part of our interview) that she felt Amber had had some great insight into her issues, Amber told me she "didn't think it was a great insight." She went on to say, "...I think, like why can't I be stronger? Like, I kind of disappoint myself. Even though a lot of people think that – there are a lot of people who think that I'm very strong, and I don't. It's (my) high expectations."

While the discrepancy between Amber's perception of her insight and her therapist's was not so serious as to cause a rupture in their relationship, it did contribute to Amber feeling somewhat less successful in therapy than perhaps she might otherwise feel.

Ishmael expressed similarly high expectations of himself regarding his anger, "The best way to stop being angry is to stop." He bemoaned his self-critical tendencies, "Why do I have to criticize myself... with all these things?

... Why is it so traumatic for me? It seems that when these things happen, I perceive them as inadequacies. I see them as being weaknesses. I see them as being inabilities. And because of that, because of my critical self, I can't accept that. I don't know how to accept (it)..."

Another way high expectations of self appeared to interfere with therapy was through the expectations participants vocalized about their use of therapy time. They gave consideration during and after sessions, as well as during our research interviews, to whether or not they were wasting time in therapy. They expressed regrets if they felt or believed they were wasting therapy time. Nathan described his experiences thus: "It means I have an active imagination and I start thinking to myself, I'm just wasting everybody's time and all that kind of stuff..." After watching her session during our IPR, Jenna said, "I shouldn't have been talking about that. I should have been using my time a little bit better, because I'm talking about things that... I don't know. I guess it's the flavor of the day..." This may well have been an appropriate and insightful response to what Jenna was seeing on tape, but it also shows high expectations that she had for herself within the therapeutic context.

Similarly, Debora expressed feeling bad, and like she was 'failing at therapy' when she thought she was not making progress in every session. Commenting on when she does not feel she has progressed in a particular session, she said, "I mean here it's wonderfully free. I mean, just the $50.00. It's an amazing deal. But you know, then you kind of feel like you didn't get your money's worth. It's a horrible thing to say, but..." It seems very likely that clients with such high expectations for themselves might tend to be disappointed with their therapy and with the amount of progress they felt they were making, *no matter how much progress they were actually making.*

Sheila observed that her high expectations, which lead her to dismiss (not just minimize) positive feedback from others, negatively impacts her relationships with others, "They're like, 'God. You never take a compliment.' I'm like, 'well, God forbid. Who cares?' You know, like – but they take it as an

insult. And I guess it would be insulting if you're trying to give someone a compliment...it's hurtful. It's hurtful. I'll come back and apologize after, but it's too late sometimes. The damage is already done..."

High Expectations of Others. Some participants indicated having high expectations of others, outside of the context of therapy. Sheila easily acknowledged her perfectionistic tendencies. She was hard on herself, and also sometimes let others know they could never meet up to her expectations and standards. For instance, she shared that she discouraged her partner from helping with cleaning in the home because "...nobody ever meets up to my standards. And that's hard on other people. Like for Calvin. He doesn't clean. There's no sense in him cleaning because he'll never measure up to how I clean. So don't even bother."

Ishmael noticed that he often got angry and irritated by relatively minor incidents or minor mistakes made by family members. He expressed frustration that he did not respond more empathetically and gently when these things happened. He also seemed to get angry at himself for relatively minor faults or mistakes. This anger seemed partly due to a 'failure' on the part of loved ones to meet his high expectations and standards. Interestingly, Ishmael was the only participant to identify having problems with anger.

Evaluating the Therapist. A number of participants made statements indicating they evaluated their therapists during and after therapy sessions. This is not necessarily problematic. It is important for clients of therapy to be considering whether or not the therapy is helping them achieve their goals and make the changes they want to make in their lives. However, on occasion, comments made by participants suggested that their evaluations might tend to be somewhat harsher than others might be in the same situation. Debora is probably not an unusual client in that she shared with me that she usually decides in one or two sessions whether or not her therapy is working and if she can work with her therapist. She also stated that she sometimes feels disappointed after sessions, if she thinks not much progress was made because she thinks she should be making progress in

every session. When her therapist responded reassuringly to her telling him she brought up a lot of pointless things in her last session, she felt relieved, "I mean, on the one hand, I mean, it's helpful in the sense that it's kind of a relief to know that, you know, you don't have to make progress every time because I always think that we should."

Another type of evaluation that occurred was directly related to the therapists' status as students. Arlene and Ishmael both made comments about their perceptions of their therapists' effectiveness and the fact that they were students. Arlene: "yeah, it makes me wonder how skilled he is. Right? I mean he's only in his first semester of his grad work. ... (Gina; 'So it raises questions about his competence-') It does! Yeah, it diminishes. ... it diminishes his rank in my mind. ... I'm very hierarchical. You know? I'm very top-dog and lesser dogs and then the peons, right? So, I look, I notice those things. I know that. ... And so, yeah, I have to fight then to not wave things aside. Because they come from a lesser being."

Ishmael had these things to say: "...But um, because I would have liked to have gone through this with her (therapist) for the whole year. And she would have grown... Because I don't know if I can verbalize it... I just really need- I just- my need is so great to be helped. And ... I need somebody who's going to be capable of helping me. ... And this person's a novice." He was also referring to the fact that he has had a fair amount of counselling prior to coming to the Education Clinic. He expressed being frustrated with his therapy because his therapist was too gentle and because he was looking for something more "profound" than he was getting in his sessions.

The difference between Ishmael's more extensive experience contrasted with his therapist's relative inexperience affected the nature of their relationship, and her ability to help him. Still, I find it interesting that he sees himself as having to 'mentor' his therapist because of these circumstances. It seemed like he had less faith in his therapist and the process and so perceived –rightly or wrongly – that he was getting less out of it. It also may have affected whether or not he was willing to disclose the

important issue he identified with me but was not discussing with his therapist.

Paul reported initially having very high expectations of therapy, "...when I first started coming here, I sort of expected like therapy would kind of solve all my problems, and well, it's obvious that that hasn't happened or I ...I don't even think that it's going to happen." It is to his credit that Paul adjusted his expectations based on his experiences of therapy, so that they were more realistic and achievable.

2. *Negative Outlook on Life*

One overall theme that was striking, yet not unexpected if one is familiar with literature on depression, was the theme that at times, participants tended to have a rather negative outlook on life. They showed some evidence of tending to anticipate future negative events, of anticipating judgment and criticism from others, and of minimizing and discounting themselves and their own accomplishments.

Some of the participants sometimes anticipated judgment from others, including their counsellors. Arlene made a wry comment about how her (current) therapist consistently "disappointed"[15] her by not judging her. There was energy spent on fearing the 'coming judgment' of others, including the therapist. It is easy to see how expecting judgment might negatively affect one's relationship with others. It also shows how interpersonal relationships might be a source of stress and anxiety much more than a source of comfort and reassurance. Having a bias toward expecting judgment from one's therapist, as some participants here did, would likely make an individual perceive the therapeutic relationship as less comforting and affirming.

Similarly, as has been alluded to, if one has a tendency to minimize and discount oneself, this often spills over into the counselling relationship, and appeared to do so with some of the participants in this research. At times, they did not notice their progress or improvements until someone else – either the therapist or another significant person in their lives – pointed it out.

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[15] Arlene did not say explicitly, but the impression I received was that she had felt both some genuine disappointment and some relief when her therapist did not judge her as expected.

Some participants also verbalized expectations of future negative outcomes or events. In fact, participants did not only have an expectation of negative future events, but sometimes a dread of the possibility of future (or present) positive events, for various different reasons All of these can serve to impede progress in therapy.

Expecting Judgment. Arlene, commenting during IPR about a moment on the tape of her session, said, "Yeah, I'm waiting for judgment. Because you know...I've done this before. This is a persistent problem for me, and yeah, I guess I am waiting for judgment." She noted that she did not get it, and I asked her what that was like for her. "Different. Definitely different. (Pause) Almost like I've gotten away with something when it doesn't happen... It's what I expected to come next."

Debora also shared some of her fears that her therapist would judge her on several different fronts. She had previously had a therapist express doubts about her career abilities, and so anticipated and feared it could come from her student therapist. She also worried that when her therapist found out she was having some recurrence of her depressive symptoms, he would be disappointed in her. In fact, Debora was highly attuned to the reactions of others and the possibility that others were judging her. She related an experience where she felt judged by her therapist "before she even opened her mouth." That therapeutic relationship was short-lived, and Debora sought out a new counsellor.

Debora explained she believed she is very sensitive to what other people are thinking and feeling and able to discern reactions that most other people would miss. She also revealed that she is very sensitive to having her feelings hurt. I interpreted this as a kind of hypervigilance against anticipated negative reactions from others. This is present in Debora's therapeutic relationships as well as outside of that context. She stated it was a "legitimate problem" for her "in the sense that I see a look of kind of judgment on someone's face and then I, like I see it and it's very clear to me. You know? And I read people well."

Anticipating Negative Outcomes/Events. Some participants gave indications that they were anticipating future negative outcomes or events. When things were going well for Amber, she worried and feared it was "too good to be true." She noticed she had made progress in therapy, and "that's what makes me happy. It's just I'm nervous that it's gonna fall apart." Sheila also indicated expecting negative events in the future; "Because you know it's coming. You just – how bad is it going to be this time (laughs), is how you're thinking."

Nathan expressed dread during our research interview, commenting on feeling like cringing each time I reached for the remote control to stop the videotape. He said, "it's – I just – probably has to do with the anticipation being half the fun. That I'm sitting here anticipating it all being, you know, just ..." He went on to explain his dread stemmed from his feeling and belief that in his session, he had been "sliding off into irrelevancies" and he most definitely was not looking forward to or enjoying watching that.

Another way that expectations of future negative events seemed to manifest themselves with the participants was through fear of losing happiness. Like Amber, Arlene expressed fear of success. She identified two reasons for that fear: first, "fear of success because success demands more performance for you," and second, "the other thing that came to mind ... about tolerating it, um (pause) because it can be taken away. Fear of it being taken away, so I'm going to take it away myself. I can control that." So, success – here it would be therapeutic progress – is experienced as inducing fear, because it can be taken away. Sometimes, it was more than just expecting bad things to happen. It was not knowing how to handle good things when they came. Arlene made a comment I found startling: "I can't stand you know, the feeling. I can't stand the feeling of goodness. It's like I don't, I literally don't have the skills to tolerate it. I haven't been taught how to handle happiness."

Minimizing & Discounting Oneself. One phenomenon that I see having the potential to seriously limit the effectiveness of therapy was the tendency for the participants in this research to engage in minimizing and discounting

of themselves. They tended to minimize the progress they were making in therapy, or to simply be unaware that therapy was actually helping them and that things were improving. As mentioned above, both Sheila and Amber revealed a discrepancy between their own and their therapists' perceptions of therapy.

Sheila was unaware that therapy had been helping until her partner pointed it out. She was inclined to brush off anyone's compliments to her about herself, or her performance (e.g., at work). Amber brushed off her therapist's feedback that she had had a "great insight" during therapy, commenting, "I didn't think it was a great insight." Arlene also acknowledged having difficulty noting her accomplishments. When her therapist pointed out her accomplishments, "I have to sort of - I have to just listen. And I have to sit with it. And sometimes I just stare at him. It's like, uh, right. Okay that's an accomplishment. Okay. And you know, sometimes I'll react like, yeah, you're right. You know?" She explained she was trying not to discount and dismiss her therapist's comments.

Ishmael seemed to have trouble maintaining his confidence in his abilities when a colleague discounted them and refused to give him credit for them. He indicated in his comments during our interview feeling very frustrated when that colleague would not acknowledge his abilities. He asked, "So the question is, why was somebody with my experience, 30 some years of experience, who knows he's a good (worker), why does he now feel that, that he's been threatened by this man? I cannot convince this man that I'm a good (worker) and I'm worth whatever."

Debora similarly needed to have "...somebody point out my strengths...Because I don't necessarily see them. And sometimes I know that they're qualities that I have but I don't see them as strengths." She also said that often when "nobody says that it's a good thing then I kind of just completely discount it." It was like participants had no trouble evaluating and deciding when they had done wrong, had disappointed themselves or others, had failed to meet their expectations, and so on, but could rarely

evaluate themselves and see when they had done well, met their own or others' expectations, and made positive changes.

Another significant way participants minimized and discounted themselves was partially manifested in their participation in this research. Nathan was the most obviously uncomfortable participant. He told me during our interview that he participated in the research because he wanted to help those who were helping him and others. In a follow-up interview, he shared that, although he did not recognize it or admit it to himself until long after and many therapy sessions later, part of his reason for participating was to punish himself. He was benefiting from therapy and doing something good for himself, so part of him felt he had to go through something hard and uncomfortable as well.

Jenna was not so reluctant to participate or so uncomfortable, but had really desired on the day of our interview to just take time for herself, to enjoy the day and the weekend. She did not request to reschedule our appointment. She thought she might be disappointed and feel that she had missed out if she did not participate. "And I kept telling myself I didn't want to do this, right? Coming today. And I thought well, two things. One, it's helping her (referring to me, the researcher). It's helping others possibly. And two, strangely maybe it will help me. And so I pushed myself to come in and do it. Even though there was this little, this little voice somewhere in the head going, now, this really is not what I want to do it, but okay."

While we all need to be able to tolerate discomfort and to manage some pain, in a peculiar way, it seemed that participants sometimes opened themselves up to more discomfort than they would have had to or wanted to experience. On the one hand, there were things they did in session and out, to protect themselves from being hurt or rejected. On the other hand, by minimizing themselves, their accomplishments and their needs, and discounting their feelings, participants may have experienced more pain, discomfort, disappointment and feelings of failure than they would have had to feel.

B. The Self-Critical Approach to Relationships

The second major area where self-critical tendencies made an important difference was in participants' relationships with others, including their therapists. Feelings of being misunderstood, wanting the therapist's approval, fearing failure, shame, and rejection all impacted the way participants interacted with their therapists. Negative and sometimes harmful experiences during therapy also impeded both the development of a positive therapeutic alliance and progress in therapy.

1. Interpersonal Issues: How do others see me?

There were several ways in which very self-critical participants handled or reacted to interpersonal relationships that appeared to impede or certainly have the potential to impede therapeutic progress. There were numerous instances where participants seemed to feel misunderstood by their therapists, and that contributed to getting "stuck" in therapy. Very self-critical participants also seemed to hold within themselves an underlying belief I have heard expressed as: "I am fundamentally flawed." Sometimes, this belief was directly or indirectly reinforced by other people significant in the participants' lives. When that happened, it made progress more tenuous and difficult. Participants revealed a need for approval from others that kind of parallels in a way the challenges they experienced giving themselves approval and recognition. Developing trust did not appear to come easily to most participants. Lastly, interpersonal relationships, including the therapeutic relationship, were sometimes negatively impacted by participants' awareness of and attention to issues of rank and power in relationships.

Feeling Misunderstood. When watching the tapes of sessions during the IPR portion of the interviews, participants indicated feeling misunderstood by their therapists. They felt misunderstood when their therapists chose an intervention that, for whatever reason, did not "fit" for them. There was no set type of intervention that did not fit; nothing that I could easily generalize to other clients. The link between SC and feeling misunderstood is not clear, but the phenomenon was evident across all participants. It seemed

important to include this as part of the therapy experience that these particular research participants were having.

Feeling misunderstood could result from an intervention that betrayed a lack of understanding of a client's approach to the world, such as when one therapist asked Amber to make a list of the qualities she would want in a partner. This simply did not fit with the way Amber thought about that issue. Debora felt that the way one of her therapists had asked her about depression exposed a lack of adequate understanding of the phenomenon and experience of depression. "...The question made no sense to me. And I had difficulty answering it. And then... she wanted to like, anything that I said, she wanted to just focus on and kind of fix. You know? Like, if we can fix what I'm depressed about, then I can be not depressed." From her perspective, the counsellor did not understand depression and did not understand her or what she needed.

Occasionally participants openly disagreed with their therapists about what to work on. Arlene gave a clear instance of where she felt her therapist had moved on from an issue too soon. "And so I had to really fight with him there for about 5 minutes. And it was like, 'we're not done.' You know? (Laughs) Yeah, and I really did have to fight with him with it. And you know, he didn't understand that we weren't done." As Debora described, sometimes her therapist's comments seemed to "come out of left field," so she did not really follow the logic or reasoning of why the therapist was focusing on a particular issue.

On occasion, participants let their therapists know when the intervention did not suit them. When they did, it seemed to strengthen the relationship and bond. For instance, Arlene said that having her therapist go back to what she felt was unfinished helped strengthen their relationship. However, participants were not necessarily forthcoming about when an intervention did not work for them or suit them. I do not know if Amber told her therapist that making a list (mentioned earlier) felt like the wrong approach for her, for example. They may have decided not to say anything because they did not feel it was important enough, because they did not

want to hurt or upset their therapist, or because they wanted to avoid a confrontation. Given that many people experience confrontation – even when you are the one confronting – as quite anxiety-provoking, this latter reaction is not so surprising or unusual.

Paul told me that sometimes it seemed like his therapist was digging for things that weren't there. "I guess it doesn't really bother me or anything. It's just like, I just kind of see him...he's always kind of digging for something else. Sometimes there just IS nothing else. So it's kind of, uh... I guess he doesn't really ... know the situation or doesn't really understand what I'm saying."

Participants like Debora and Ishmael felt misunderstood when their therapists did not seem to grasp how serious they felt their concerns or problems were. Ishmael for instance felt that initially, his therapist had been too gentle with him. "It's not that I hate it (her approach). It's just that I feel, I feel like, um, I want, I'm impatient. And I want to get to issues and to the depth of issues." Jenna indicated not feeling understood when she felt she was getting the same single solution to her problem over and over from previous therapists, instead of being provided with alternatives.

Sometimes, attempts to normalize a client's experience were perceived as minimizing and discounting his/her concerns, and contributing to misunderstandings, like when Debora's current therapist attempted to normalize her experiences as the everyday ups and downs that people experience, and not necessarily depression.

> ...It's a mixed bag, because on the one hand, he's kind of in a sense, minimizing my – the amount that I was concerned about the return of certain patterns of behaviour that are red flags for me. But on the other hand, in a way, his minimizing them is comforting. Because whereas I see it as, 'oh my God, it's all returning.' He sees it as, 'well, no, I mean this is like just this blip.' Like it's not a huge thing.

The relationship between Debora and her therapist was quite strong so easily withstood this minor misunderstanding. Her response does however show how tricky it can be to navigate through these types of 'waters' in therapy.

Debora shared a story of a previous therapist who had a 'pet theory' for some of her behaviours, and tried to impose his views on her. There were some similarities between what had happened in his family and in hers, so he apparently believed the causes and ultimately, the consequences were or would be the same. His 'story' of her life just did not make sense to Debora, yet she found him "tenacious about it. Like, he just would not let it go." It was clear Debora felt her therapist did not really understand her.

Feeling "Flawed" Reinforced by Others. Comments participants made revealed that they received criticism and negative messages about themselves from significant people in their lives. These messages could have easily reinforced the self-critical tendencies participants had. They also could have easily undermined efforts being made in therapy to reduce self-criticism and increase positive self-views.

Sheila, for instance, described her relationship with her mother thus, "You always end up feeling like the bad one. It doesn't even matter if she got her way. In the end, she's still going to make you feel like shit, either way." Amber noted that one of her friends seemed to think she was taking too long to grieve, that she should have moved on already. Arlene shared how a family member had recently started to make critical comments about her and her choices, but she stopped this cold.

Ishmael disclosed that he received many mixed reactions and different kinds of feedback from his parents. They seemed to have low expectations of him: "I think what they saw for me was, that I was going to be - I was going to go out and work. Labour. Somehow. Um, like they didn't expect anything more than that." They talked proudly to others about his artistic abilities, but rarely to him directly. His father apparently criticized him mercilessly at times, denigrating the way he walked and talked, waking him at night to hurl abuses at him.

There were some indications that participants had negative reactions from others regarding their involvement in therapy. Nathan mentioned that his wife did not really support his going to therapy (at least initially). In our interview, he told me he felt fairly certain that his wife was expecting the result of therapy to be him leaving her. Furthermore, his wife thought counselling was for "crazy" people. If a person needed it, there must be something really wrong with him/her. So Nathan attended therapy with a bit of hesitation and concern that it would, in fact, increase problems in his marital relationship.

Nathan also shared his concern that a former employer would not have approved of him coming to therapy. He said

> I mean, if I was still working for my old employer, I probably wouldn't be here. Just because, I mean, he made a point of making sure there was no ... nothing in our benefits package to assist in this kind of a thing, at all. Because he - I mean, anybody who might need counselling or anything along those lines, had to have something wrong in their head, and he didn't want them working for him.

These kinds of influences can hardly have made it easy for Nathan to come to counselling, something he (and most clients) already found hard to do. To an individual who is already very sensitive, as very self-critical individuals are, to judgment and criticism from others, lack of support from one's social system could very well serve to threaten or undermine therapeutic progress.

Not Trusting Enough to Tell the Truth. Participants in my research also gave indications that their ability to build trusting relationships with others affected their therapy. They often had what I have called "hidden issues," significant areas they felt they needed to work on, which they had not revealed to their therapists. In addition to not revealing these hidden issues because of fear of rejection or judgment, I wondered if participants kept things from their therapists because they did not trust them in some way.

Ishmael was not sure his therapist could handle 'the truth' if he told her. "I feel free to talk to her about things. What I am concerned about is

whether or not she can handle (it). ... so, your personal feelings – I mean, I could be a real challenge for her... but I don't know 'til we get there, if we do get there, whether – how much of a challenge that would be..."

Nathan admitted that he had tested his therapist to see whether or not he could trust her, and if she would be receptive to him being open and honest with her. She had clearly passed the test, and he indicated that he was able to let her know about some of his fears of her rejecting him *because he had* tested the relationship. It seemed to me that participants found nonjudgmental therapists to be more trustworthy than ones they experienced to be judgmental.

Arlene provided two different examples of the impact of a lack of trust in the therapeutic environment. First, she related how she had felt much less safe in group therapy situations than in individual ones. This lack of trust sounded more related to the situation than to the particular therapists. The result was that she explained she tended to "perform" – which she defined as figuring out what was expected of her and delivering that – instead of working on what she really needed to. The second instance related to her individual long-term therapist, and an incident that occurred early in their relationship. The verbal and nonverbal reactions she got from her therapist when she began to talk about childhood trauma led her to believe her therapist did not want her to talk about that topic (although it may not have been her therapist's intention to send this message). Whether the reaction was because the therapist did not know how to deal with it or was afraid, she did not know. She explained to me that she had never fully trusted this therapist as a result. Despite this lack of trust about a key issue, Arlene described this individual as her "long-term therapist." It is difficult to know how this lack of trust affected their relationship and what Arlene was able to accomplish in therapy.

A number of the participants were nearing the end of their work with their student clinicians. This brought up discussions about the necessity of changing therapists and finding someone new to work with. Jenna commented, "It's really hard, because I – and I think because I feel like I've

made a connection with her and it's hard to, I'm like, 'No!' I don't want to go and start all over again." Obviously, each person who was wanting or planning to continue in counselling would have to develop a trusting relationship with a new therapist.

Wanting Therapist's Approval. Wanting the approval of others is a natural human phenomenon that occurs on a long continuum. At one end are the sociopaths, who care nothing about what others think and act without regard for others. At the other end of the continuum are the people like the man in one of Aesop's fables, who drops his donkey in the river in his efforts not to offend anyone on the way to the market.[16] Debora, Ishmael and Jenna all indicated having concerns about their therapist's approval on some point. Debora: "And so I think that while I was describing what I've done this week, I was, I think I was trying to put a positive spin on it, you know... I want Fabian (therapist) to approve. Which isn't healthy..." Ishmael approached his therapeutic homework very conscientiously, and agreed that he did want his therapist to approve of his work. Jenna expressed worry that she was disappointing her therapist when she kept returning in therapy to an old issue, "rehashing it," in her words.

Arlene indirectly indicated wanting approval from her therapists by figuring out (in the group situation) what was expected of her and trying to provide that, rather than addressing her own issues. In individual therapy, there may have been some influence of wanting approval from her long-term therapist when she chose not to explore a significant issue that she believed her therapist was uncomfortable (or unable to deal) with. The way she circumvented concerns about acceptance or rejection by her current therapist, was by avoiding the "personhood" of that therapist, so she could focus on herself and what she needed/wanted to accomplish in therapy. She had a clear task or objective that she wanted to accomplish in therapy, and she focused on that, seemingly avoiding the 'relationship' part of therapy. In an email exchange after our interview, I asked Arlene, "Do you

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[16] The reader can contact me for the full Aesop's fable, or check online at http://www.pagebypagebooks.com/Aesop/Aesops_Fables/The_Man_the_Boy_and_the_Donkey_p1.html.

have a sense of what it would have been about having a more personal connection with (your therapist-name deleted) that would have interfered with your work?" She replied, "I would have paid attention to how what I was saying or doing would have affected him. As it was, when I revealed something distasteful about my past behaviour to him, I was aware of both the shame of it, and the fear of how he would reject me because of it."

Sheila acknowledged wanting to present well to her therapist: "...Because I would probably like him to see always the good side of me. But obviously that doesn't happen, because he picks up on things that I haven't - that I meant to hide from him or everyone else. And he'll find it or... I'm like 'my God, I'm not camouflaging too well' (laughs)."

Rank or Power: Who is the Top Dog? The issue that I describe as 'rank' or 'power' came up in a couple of interviews. When I use those terms, I am referring to the idea that an individual could be perceived as having a rank (or worth) above, equal to or below another person. Relationships are also at times understood and experienced as involving power. For example, one person might have more ability to dictate the nature and timing of a therapeutic relationship. Sometimes, power is understood as the ability to make someone else do something.

Two participants were quite aware and willing to mention issues I saw as related to rank and power. Arlene and Ishmael discussed their therapists' relative 'novice' status during our interviews. Arlene, for instance, commented about having to make sure she did not dismiss what her therapist had to say, knowing he was a first year student. As mentioned earlier (see "Evaluating the Therapist"), she had to "fight" with herself "not to wave things aside" because they "came from a lesser being." She stated she was very aware of status and rank, and said she was "very hierarchical."

Arlene seemed to indicate that she expected her therapist to have some power or authority over her. I inferred this from her remarks about getting away with not working in therapy, "Like, even when I was in the (other) program, they'd pick up on some things but miss other things that I thought were more important. And I got away with them. You know." Later

on, she elaborated, "Like, uh, Dr. Smith at the hospital, if he let me get away with something, it'd be like, yeah-huh? Guess who just won! (laughs)." It seemed Arlene had the expectation that part of her therapist's job was to make sure she was not dancing away from and distracting from what she needed to be working on.

In many ways, this just makes sense. People need someone else to help them figure out what they need to work on and how in therapy, otherwise they would not be there. Most people have tried to do it on their own before coming to therapy, and were unable to do it. What's more, as Debora observed, it can be easier to just chat than talk about one's problems. The reasons people come to therapy are often painful to discuss. What was different here, perhaps in degree rather than kind, was how not working in therapy was "getting away with" something. There's a sense of a power differential implied. Arlene was 'winning' over her therapist when she got away with not working, it seemed.

Ishmael was aware of rank and relative power in a somewhat different way. He described feeling like a mentor to his therapist at times. Unlike Arlene, he did not want to get away with not working in therapy. He wanted to work much harder than he thought he was currently working. He said,

> ...I need somebody who's going to be capable of helping me....And this person's a novice. And that for me, in a way, I'm put back in the situation again, where I'm - like in a sense the mentor. Which means I'm experienced. That means I'm ... in a sense I'm a force to be reckoned with. Because I already know lots of stuff.

The role of mentor was not one he wanted to take on in the therapeutic environment. He described himself as an onion, and only the first, thin layer had been peeled back, whereas he wanted to go many layers deeper than that.

There were other ways rank or power issues were expressed by participants. Nathan commented on feeling equal to his therapist, that she

didn't have any power or authority over him. He indicated this was important to him and that he would have found therapy less helpful if the relationship were less egalitarian. In fact, Nathan was very aware of rank and power issues even in our research interview. It was important for him that the interview occur on 'neutral territory,' a place that was neither my territory nor his. It is hard to imagine that this hierarchical orientation to the world would not have affected how his therapy progressed.

"Hidden" Issues. One very important finding of this research was that participants kept certain issues secret from their therapists, despite believing that these issues would need to be addressed in order for therapy to be successful. They had many different reasons for not disclosing these problems. Sometimes it related to how much they trusted their therapists. At times, as with Arlene, the decision to withhold information was made because of actions of the therapist and the meaning ascribed to those actions. Often, shame and fear of rejection were the motivating factors.

Participants in this research kept some pretty significant problems hidden from their therapists. There were no doubt many reasons participants did not tell their therapists about some of these issues, including fears that they (or their therapists) did not have the resources they needed to successfully cope with exploring and resolving these hidden issues. In that sense, their attempts to improve their lives through therapy would "fail" if they addressed those issues.

For instance, one participant who thought that her weight was a significant problem that needed to be addressed said to me during our research interview, "I feel like there's an elephant in the (therapy) room, and the elephant is me." She did not bring this up with her therapist because she felt unable to handle addressing it at that time, but she seemed to feel quite bad that she not brought the issue up in therapy. Issues of gender and past sexual abuse were among the topics not being disclosed to the participants' therapists.[17] More importantly, the participants themselves

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[17] I have not attached these references to any particular participant because I felt the need to take extra steps to ensure their anonymity and confidentiality.

identified that these not-yet-revealed issues were the important ones they felt needed – eventually – to be addressed. In some cases, it was a matter of not being ready to address the particular issue. For other participants, lack of trust, shame and/or a fear of rejection kept them from telling their therapist.

2. *Fears and Responses to Them*

The people who participated in my research indicated having several fears that were linked to their relationships with others. Fear of failure, fear of rejection and shame were the three fears for which I found evidence. This category also encompasses what I saw as thoughts and behaviours that the participants engaged in as a response to some type of fear. Generally, the responses outlined here were the maladaptive ones.

Fear of Failure. One fear that I suspect interfered with therapeutic progress with some of the participants in this study was/is the fear of failure. This may not seem obvious, at first. What is it self-critical clients fear they will fail at with regard to therapy? Amber expressed a general fear of failure in her life, while Debora identified the specific fear of *failing at therapy*, and thus disappointing her therapist,

> But I've been feeling... a little bit more depressed this week and ... I thought about not telling Fabian about that. Which is huge. I mean, like, and the reason that I didn't want to tell him is because ... um, I didn't, because I knew that he was pleased that I had managed to uh, overcome my depression and I didn't want him to think that I was backsliding... and that I wasn't doing well, you know. Almost a fear of failing at therapy. (laughs).

A positive development was that she shared honestly her symptoms and fears with her therapist and he normalized some of her experiences for her. None-the-less, a very self-critical client might be tempted to use some 'impression management' strategies to hide things if s/he thought or felt that s/he was 'failing' at therapy.

Fear of Rejection. Not surprisingly, fear of rejection impacted participants' relationships with their therapists, as well. They were attuned to possible rejection from their therapists. Arlene, for example, shared how she had momentarily felt rejected when her therapist recommended moving from twice weekly sessions to once weekly. It was my understanding from our interview that the reason Arlene's therapist had suggested this was that he felt she no longer needed therapy twice a week. What might typically have been viewed by others as a sign of progress was initially interpreted by Arlene as rejection.

When participants experienced rejection from their therapist, whether intentional or not, it had a significant impact on the therapy. When Debora received a comment from a therapist that she felt was judgmental, she stopped seeing that person and began seeing someone else. This is not a criticism of her decision to see someone else, and indeed she told me the new therapist had been very helpful. What was noteworthy was that Debora felt there was no room for any discussion with the therapist about her inappropriate comment. "... But the first therapist was um, I thought she was reasonably good, but then she hurt my feelings. So, I, so I didn't go back... But I didn't think there was any discussion we could have about that. That was just judgmental... I stopped seeing her and started seeing someone else, who was actually quite good."

Earlier I mentioned how participants indicated they were concealing significant issues from their therapists. I believe one reason for this was fear of rejection from the therapist, if the full truth were revealed. When participants felt safe to be honest without fear of rejection from their therapist, or when they felt prepared to cope with the possible rejection, then they were more likely to be fully disclosing, enabling the therapist to help them work on the difficult and sometimes shameful issues. Ishmael was unwilling to bring up a particular issue with his therapist, even though he told me he thought that if he resolved this issue, some of his other issues would be resolved as well, because he was not sure his therapist could "handle" it. Part of this related

to his perception of her skill level, but another part seemed to me related to his fear of her reaction if he revealed this issue to her.

Arlene commented in our research interview on how she had ignored the "personhood" of her therapist to the point where at times, she could not remember his name. In a follow-up interview, she shared that part of her reasons for doing this was because she was afraid that being aware of the personhood (personality, individuality) of her therapist would make her too fearful of possible rejection from her therapist to work on the issues she needed to address. "I would have paid attention to how what I was saying or doing would have affected him. As it was, when I revealed something distasteful about my past behaviour to him, I was aware of both the shame of it, and the fear of how he would reject me because of it."

Shame. Fear of rejection and shame are no doubt closely related. Feeling shame about some aspect of oneself contributes to one's fears that others will be rejecting if they find out about the shame-producing aspect, thought or action. Jenna indirectly indicated that shame had prevented her in the past from fully revealing her problems to her previous therapists.

In addition to her fear of failure and fear of disappointing her therapist, one reason Debora was hesitant to bring up her depression with her therapist seemed to have been shame she felt: "...one of the reasons I was hesitant to bring up the depression was I kind of felt it was a huge backslide and it felt like, 'oh, he's going to think that's, I'm not doing very well' and maybe, you know, he'll in his mind be thinking, here we go. We gotta start back at the very beginning."

Some participants also made comments suggesting they were experiencing shame as they were watching the video of their therapy, during the IPR portions of the interviews. Paul expressed feeling embarrassed watching the tape because he noted so many times when he felt he could have said things better than he did. Nathan stated he felt "dread" about seeing the "derailment" he felt he had instigated in his therapy session. Debora commented "...even now that I'm speaking to you, I'm imagining

the way that I look speaking to somebody on the screen and it's, it's like a – it's kind of a nightmare, you know."

Participants also expressed fears of being hurt and especially of being judged by their therapists. A therapist who was perceived as nonjudgmental was very important to most participants. Participants were unlikely to be able to develop a trusting relationship with a therapist whom they perceived as judgmental. The reader only has to recall Debora's immediate termination with the therapist she felt was judgmental to see how an apparently judgmental attitude on the part of the therapist can interfere with the development of a trusting therapeutic relationship. Debora did not give that therapist a second chance.

Maintaining Control. In response to what I saw or interpreted as a fear of losing control, participants took steps to maintain control of themselves and their experiences during therapy. There were a number of ways they worked at maintaining control. As with most of my findings, few if any strategies were used by everyone in the study. This is not to suggest that maintaining control or feeling in control is necessarily problematic. In fact, for most people, having a sense of control of themselves and their environment is essential to being able to function in daily life. Learned helplessness results when people or animals are unable to control their environment or what happens to them (see for instance, Abramson, Metalsky, & Alloy, 1989; Abramson, Alloy, & Metalsky, 1995). What I am attempting to highlight in this section is when maintaining some type of control interferes with therapeutic progress.

One way participants maintained control was by being cautious with what and how participants said things to their therapists. This seemed to be done to limit what participants revealed about themselves. For instance, Arlene made a conscious choice not to reveal certain things about herself in a group therapy setting. I believe participants were thoughtful and judicious about what they said about themselves in part out of a *fear of rejection*. They tried not to reveal parts of themselves either they did not like or want known. Sheila said, "Usually when he'll catch me in something I haven't said.

That it's been something that's nonverbal. And he'll say, like, I get from the way you're sitting or the look that you just gave me that – and I'm like, damn it, you can't hide anything from this man!" They also tried to conceal parts they thought others would not approve of. Paul commented, "...on the other hand, I'm, I am I would say, you know, cautious about what I say."

Some participants expressed a need to control the therapeutic process. This is not necessarily problematic, as it is important for clients to be invested in the therapeutic process and to be actively working towards their goals (see Bordin, 1979, 2000; Horvath & Luborsky, 1993). They made a variety of comments about controlling the process. Nathan indicated, for instance, that it was important that he feel equal to his therapist and stated he did not perceive her as an authority figure. "I mean, it's – she's never been in the position where I've sort of perceived her as the authority...It was very quickly given to me that basically we were on a level playing field. It wasn't a question of her being any kind of an authority figure."

Ishmael, by contrast, indicated being vigilant and concerned that he was controlling and directing his therapy too much. In fact, during the IPR portion of our interview, he asked me, "I want to ask you something. From what you, from what you see, do you feel that I'm controlling the... process? Or do you think what is happening is what should be happening?" He also shared that he was aware of making comments that he hoped/anticipated would open certain lines of questioning from his therapist. Just as I mentioned earlier that Ishmael did not want to be in a position of rank or power above his therapist (e.g., mentor her), he did not want to be too controlling of his therapy.

Arlene also highlighted ways in which she maintained control of her therapy. In one instance that came up during our interview, she told me of a time when her therapist moved away from a particular issue before she felt she was done dealing with it. So she redirected her therapist back to it so she could finish what she needed to do. Arlene also observed that she sometimes gave her therapist mixed messages about control, at times indicating she wanted her therapist to lead and guide the process but at

the same time she wanted to maintain control herself. "...I didn't want him to take this process, I really don't want him to take the process away from me and yet I want him to be in control of the process. You see what I'm saying? Like, it's sort of a – I want your help but don't help me."

I think one of the potentially most damaging ways participants tried to maintain control was their controlled and cautious approach to happiness. For example, Amber commented, "Um, because of all the stuff that's happened in the past, I kind of think it's like too good to be true. Almost (to) be this content. Like, something's going to fall apart. And I know it's a really bad belief to have, but like, I'm just scared." Arlene commented that she had recently worried when she was feeling happy that she was experiencing mania and that maybe she was manic-depressive. She went on to say, "Tolerating happiness is very difficult for me." In our follow-up interview, she told me she does not believe she is afraid of being happy but does not have the "skill set" to know how to handle the experience.

It does not seem difficult to imagine how a client's discomfort with feeling or being happy might impede therapeutic progress. Participants expressed a desire to feel happier, and identified this as one of their reasons for seeking counselling. I can imagine, however, that the closer a client approached this state of happiness, the greater the difficulty to continue making progress.

Coping by Avoidance. One way to cope with fear of failing – at anything – is to simply *not start*. It stands to reason that you cannot fail at something you did not begin in the first place. A classic depressive and self-critical strategy for dealing with a problem is to cope with it by avoiding it. A common way participants coped with fears, as well as discomfort was by avoiding things. This is not to imply that avoiding a particular issue at a particular time is necessarily problematic. Sometimes for a client, it is a matter of self-preservation. However, coping by avoiding is a strategy that has been linked to depression (e.g., see Yapko, 1997; 2006), and can interfere with therapeutic progress.

During our interviews and IPR, participants revealed there were significant issues they had that they believed needed to be addressed in order for therapy to help them achieve what they wanted to achieve, but which they had not yet (or had not in the past) revealed to their therapists. They had a number of reasons for not having revealed these issues. In Nathan's case, he had not revealed the issue because "...the whole thing isn't worth going into but, I yeah, there's a rather large issue around that. It's difficult ... pretty much to be open with anyone about it, including me... And I'm not entirely certain I was open with Jeanne (his current therapist) about it... I think she understands that I'm just not ready to – I'm ready to deal with it in small bites, and I'm not quite up to taking on the whole thing yet... I could probably take a month with her on it. (laughs). Straight."

Paul shared during our interview, "...well, I want to say he hasn't got the real issue. *That's because I haven't told him the real issue*.[18] He hasn't really had any insight on that." As mentioned earlier, Ishmael indicated being quite aware that there was a significant matter he had not made his therapist aware of, which he thought it might be the key to resolving the problems he had been having with anger. His reasons for not disclosing were because he was unsure his therapist would be able to handle knowing and to help him dealing with it, and he felt there was insufficient time for them to resolve it before he had to end therapy with her, so he did not even want to start. These were quite possibly valid concerns and a realistic assessment of his situation. Clients were limited in the amount of therapy they could receive at the Clinic by the length of the academic year.

Participants were sometimes but not always aware of distracting themselves and their therapists from what they understood to be the "real" issue. Sometimes, they realized upon reflection after the session (or during the IPR portion of our interviews) that they had engaged in avoiding and distracting from the important issue, although they were not aware of doing it at the time. Often a participant might avoid something because it was a painful topic. Amber said she had a "wall" that protected her and also

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[18] Italics added by this writer.

seemed to protect others from seeing her vulnerable, hurting parts: "I guess now I don't like talking about it (her sister's death). I can tell I don't like talking about it... I just, I feel like it' such a horrible thing that happened and I don't really want anybody else to – I don't know. I'm very, very weird with like, I- nobody can see me down. Nobody can see me, like, hurting and this and that."

Jenna similarly noted that her therapist had had to work very hard to get her to "connect" to her emotions. Nathan described it as "It's... logical brain vs. emotional brain..." During our interview, it seemed like Nathan's "emotional brain" was the harsh, self-critical part. When we watched his tape, he made many comments about how he thought he had been "sliding off into irrelevancies" during the session. He also expressed a great deal of criticism regarding what he was talking about during our interview, fearing that it was not what we were supposed to be talking about, and that it was a waste of my time.

Sometimes the "real issue" was not being addressed because, in the participant's mind, the therapist had allowed the client to avoid it. Arlene: "...one of the things I've done with my long-term therapist is I've distracted a lot, um, danced away from the painful stuff a lot. *And ...she's let me get away with it.*"[19] With the exception of one, and possibly two, participants, all of the individuals I interviewed were currently – or had in previous therapy – hiding a significant issue from their therapists. Arlene shared in our research interview that she had believed, based on her long-term therapist's[20] reaction to her beginning to talk about traumatic childhood events, that her therapist did not want her to "go there." As a result, she never felt that she could trust this therapist. So she did not deal with these issues. Yet she had continued to work with that therapist for years.

Protecting Oneself from Pain. This code is similar to 'Coping by Avoidance' and refers to what I saw as a similar kind of problem-solving approach. When I use the phrase "self-protective behaviours," I am referring

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[19] Italics added by this writer.
[20] This was not the student clinician she was seeing at the Education Clinic.

to behaviours designed to protect the person from experiencing pain (e.g., avoiding painful topics) or from experiencing negative reactions, such as hurt or rejection, from others. For instance, Arlene said this about closeness, "I reject closeness and will do anything that I can to possibly destroy it." She observed that she had avoided becoming too aware of the 'person' of her therapist, at times even forgetting his name. She explained that she wanted to be able to focus on herself and the work she wanted to accomplish in therapy. The way Arlene protected herself from possible rejection was to keep her therapist at an emotional distance and to not become too attached or too close.

Another way of protecting oneself, in addition to maintaining control, was by choosing one's words carefully. Jenna described it this way, "Because I think that's what self-critical people do, is they keep themselves in check. They go, should I say that? No. Can't go – it's like they sort out what they say before they say it, hey?" Paul indicated that this extended beyond the context of therapy for him; "... I mean ... you always have to watch what you say, though. I mean, no matter who it is, right? Whether it's a therapist or a friend..."

Participants also protected themselves by "pacing" themselves in therapy. That is, at times they would make very conscious decisions about what to bring up and what to keep to themselves in session. They would decide – like Debora did – that they were not yet ready to deal with something, so they would not bring it up. This has both positive and negative aspects to it. On the one hand, it is important that clients be ready to deal with issues in therapy and beyond the therapeutic hour before they begin working on them. On the other hand, as Debora pointed out, "Um, it's so crazy because it's like I can't you know, help myself. Um, I just, it's so much easier to 'chat' than to talk about your problems, you know."

It appeared to me that by containing their emotions, participants also protected themselves from pain or from potentially negative reactions from others. Amber described 'having a wall' which seemed, among other things, to protect her from others, as well as to protect others from her

feelings. She expressed struggling with the belief that she should not "burden" others by bringing up her sister's death and her feelings about that. She also did not want others to feel sorry for her.

Interestingly, evaluation was also identified as a self-protection mechanism. Arlene suggested that "...evaluating someone else is a good way to shut them down and then you can ignore them. Right?" Ishmael suggested much the same thing. As mentioned earlier, another kind of self-protective behaviour that participants engaged in was keeping hidden issues they felt might be too painful to deal with. Jenna shared that during her first two experiences with therapy, she had not been entirely honest with her therapists about the nature of her problems. She alluded to hiding the details of her issues out of shame and embarrassment. During our interview, she commented that she thought her vagueness or lack of honesty had impeded therapeutic progress.

The context of therapy also had the potential to impact what participants chose to reveal and how cautious and self-protective they were. Arlene noted she had been much more careful about what she revealed of herself in group therapy than in individual, "like in that (group) situation, I felt very guarded, you know. And was very, very careful what I let out." She indicated playing the "game" of trying to figure out the expectations of the group setting and then complying with those. "Um, very hard not to uh... in those kinds of situations, I can perform quite well. Um, and do quite well. But then I give myself – I don't do the work I need to do, and get, you know, down to the crap I need to get at, right? ... Performing, um, is, I know what's expected. Or I can figure out what's expected and I will deliver that."

People may choose not to change as a way of protecting themselves. Indeed, changing oneself is often seen as a risky proposition. For Sheila, one way to protect herself was to be dislikable. She railed against being told she was changing and becoming more "mellow" as a result of therapy, because she thought this could put her at risk of being taken advantage of by others. She expressed that it is easier for her if people do

not like her. Finally, Nathan recognized the need to protect himself after therapy, "Uh, when I get outside of here, I tend to just sort of shut down again. And I – the outside world is not ready for that... Well, and maybe I'm not ready for them – maybe I'm the one who's not ready for that."

3. *Bad Experiences in Therapy*

The people who participated in this research shared a number of accounts of experiences they had had in therapy that were unhelpful at best and harmful at worst. Regardless of the fact that the participants were/are very self-critical, it seems reasonable to believe that these experiences decreased the effectiveness of therapy. Harmful therapist actions probably hinder therapy for self-critical individuals in much the same ways as they impede it for people who are less self-critical. They serve to undermine the relationship, and the trust. They could increase the chances that a self-critical person would be very cautious in therapy and 'hide' important issues, rather than dealing with them.

One interesting phenomenon was that my research participants were generally fairly positive in their descriptions *of their current therapist.* They seemed to be more willing to make critical comments about past therapists than current ones. Perhaps they all were just more satisfied with the services they were presently receiving. Another suggestion was that perhaps there was some reluctance – for reasons unknown – to make complaints about people they were currently working with. It may have been that because of their awareness of my possible affiliation with their therapists (I was honest in disclosing my student status), they were more cautious in what they said.

Refusing to Get Involved. Several participants expressed how frustrating it was for them when their therapists refused to give them honest feedback or requested advice. They did not seem to be expecting to blindly follow the advice of their therapists, but were genuinely seeking input and feedback. Psychologists often work hard at 'not giving clients answers, but helping them find their own answers.' According to the participants in this study, this was sometimes taken too far or overused.

In explaining why her relationship with her current therapist was much more helpful than previous experiences, Jenna had this to say,

> I think the biggest difference was that there was no input from their side. Where Seraya (her current therapist) actually had input. 'I want you to think about this.' You know?" She described her experiences of not receiving input, "...And I'm like, what do you think? You know, I'm getting more angry sitting there... What do *you* think? What's your input? You have the experience. You have the education. ... You kind of should have an idea of a little bit more so than me... Give me some input. Anything! I don't care what it is. Give me some input. And I found it very frustrating just to – that they sat there in silence.

There was an agony in her words that was very compelling. Arlene wondered if she were more capable of directing her therapy because of a lack of direction from her therapists at times, "...I would look to them for direction and help and it wasn't there. So...I've had mixed experiences with it. And maybe because of that, I was more capable of 'okay, alright, where do I go?' You know?"

Arlene found therapists who did a lot of writing in therapy distancing, "It's not the – my long-term counselor never writes. Has never written. And so, um, being with people who write um, in my intake at the university and um, then here. This is not typical to my counselling experience. It's interesting. So, it's a very professional tool. Very distancing, though."

Debora described past experiences of crying in therapy and having the therapist be almost completely unresponsive: "I have had the experience of being in therapy and crying and having the other person kind of ... like they're there, but it's like, they're not. I don't know how to put it. They almost don't – it's not that they don't care, but they're just kind of like, they're very detached from me and my emotions." By contrast, her current therapist demonstrated an appropriate empathic response that made her feel supported and cared for. This unresponsiveness seemed to

communicate a lack of investment in the relationship – distance, disconnection and unresponsiveness are all part of this.

Having Hope Destroyed. Several participants related incidents with therapists that they experienced as harmful. Debora shared a story of going to a counsellor who essentially told her she could not accomplish what she wanted to, that statistics said it could not be done. "But I think that's the only time I've gone to therapy that I think was actually quite destructive. And in fact, I wished I could erase the hour..." It was only an hour, but clearly it had a long-term impact.

Debora related another experience of having a different therapist tell her that her choice of careers was "iffy." This was harmful for her because she already tended to be full of self-doubt. "I'm always telling myself it's iffy. You know, that's the last thing I need is to have someone say that to me." Experiences such as these I imagine destroyed or weakened hopes Debora had for herself and the changes she could possibly make in her life.

As mentioned in "Feeling Misunderstood," Debora had a therapist who had a 'pet theory' for her life that he tried to impose on her. Similar circumstances between her and his own life led to him believing the motivations and outcomes would also be the same. Debora found him "tenacious about it. Like, he just would not let it go." He apparently lacked the insight to see how he was projecting his own issues onto her. It is hard to imagine how the two of them could have worked effectively at resolving the issues Debora was facing when they were not even in agreement about what the issues were.

Arlene also described an incident that was harmful to her, with her student clinician,

> In the very beginning, he said, 'You're a pro at this.' (referring to the fact that Arlene had previously had years of therapy). And it was like, you know, I felt insulted. And it, you know, it triggered some stuff in me, because you know, like, I don't want to be a pro at the therapeutic process. I really don't. I

> **have** to be here. You know? In a perfect world, I would be living a normal life.[21]

It was an offhand, throw-away comment, that likely reflected the therapist's nervousness and possible feelings of intimidation at having an "experienced" client, but it came across as flippant, judgmental and hurtful.

Ishmael told of an experience he'd had in marital therapy that in his opinion, further destroyed his already ailing marriage. He said he and his wife had each been given a questionnaire to complete. In his perspective, his wife had answered in a socially desirable way, but he had answered honestly. It seemed that the therapist had not effectively handled the conflict (and hurt feelings) that arose when the questionnaires were being discussed.

Lastly, there was one incident in which it was my perception that a cause of some misunderstanding in therapy had to do with the therapist's discomfort with the topic (in this case, death). I am certain that Paul would not have complained about feeling misunderstood by his therapist, yet he pointed out "I see Michael thinking about this (referring to awareness of the nearness of death), trying to get rid of it, so much. And uh, ... I was just thinking, ... it's almost something that I have to deal with and, and uh, ... keep with me, than, than get rid of it, right?" This did not so much harm Paul as harm their ability to make progress on the important issues he was facing.

Feeling Judged by the Therapist. Feeling criticized or judged by their therapists were also experienced, not surprisingly, as harmful. Debora recounted an incident with a therapist, where the relationship ended shortly thereafter: "That's what she said, that's her quote. 'So, you're grandiose in your self-deprecation.'... and I thought that was a really judgmental thing to say." Debora told me she felt she could not have talked through and resolved this incident with the therapist, so she stopped seeing that person after that session. Sheila described her sister's therapist as "so judgmental," and so was expecting a similar experience from her own therapist.

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[21] Emphasis in original interview.

Not Feeling Respected. Participants shared experiences in therapy where it seemed to me that the therapist had been, or was experienced as, disrespectful. I think these experiences are harmful to the relationship, if not to the client, and often harmful to both. Debora mentioned one person who had a favorite theory for her behaviour and experiences that absolutely did not fit for her, yet the therapist would not give it up. Nathan related a tale of trying to obtain couples counselling from a therapist nearly hidden behind stack of paper on his desk, who used a rather prescriptive approach, "...you will do this, this, this, and this. That just didn't work." Jenna described what sounded like classical psychoanalysis, except it sounded to her like her therapist was falling asleep behind her back – literally! One of Ishmael's therapists insfructed his wife to report back to him (therapist) if she saw Ishmael engage in "any inappropriate behaviour." What was surprising sometimes was *how persistent* participants were in continuing to attend therapy – despite these kinds of experiences – because they wanted something better for themselves! Their sheer determination to feel better was amazing. It seemed to me that these were people who were working hard in therapy.

C. Time Pressures: Brief Therapy is Not Enough

One unexpected finding of this research that I suspect is related to being very self-critical was the considerable amount of therapy some participants had had in their lifetimes. Six of the eight participants had at least *some experience* in therapy, and three (Debora, Arlene, Ishmael) had years of therapy, and at least one other therapist. Additionally, Nathan continued in therapy for another academic year, following his participation in this research. Sheila requested to be re-referred for additional therapy when I contacted her regarding the transcript of her interview, and Jenna clearly stated she planned to continue in therapy, albeit with a new therapist. As noted in the literature review, according to the Canadian Community Health Survey (Statistics Canada, 2003), only one-third of those respondents with depression or anxiety problems talked to a health professional about those issues. Most would have chosen to speak to their family physician. By

contrast, three participants in this research had years of therapy with multiple therapists.

One way to interpret this finding could be to note how proactive participants were in seeking help and working on changing themselves. While some of them had "quit" working with a previous therapist, they had not given up on therapy entirely, just on the specific relationship. However, it must also be considered that achieving a 'successful' outcome in therapy did not come easily for the participants.

Participants seemed to be aware sometimes that they needed a long time in therapy in order to make the progress they wanted to. Ishmael said, "Because I think – because I think if, the longer I'm together with a – in the counselling, with a given (counsellor), I think the more I will shed the barriers. Things that I – that I might not even be aware of." He went on to say he might not have started therapy when he did, had he known he would have to change therapists so soon. He would have preferred to wait until the new term so he could have longer to work with the person.

There were a number of ways that the need for long-term intervention was made evident. Ishmael: "But...I need more out of life than that. And so I said, I need... I need help, but my insurance will only pay for 6 or 9 sessions. Well, I can't get anything out of nine sessions. I know that." Several participants talked about their frustration at having to end with their current therapist (in this case due to the end of the school term), particularly when they were finally starting to see progress. Jenna described the progress she was making at the time of our interview as a "windfall." She noted it was disappointing to have to end right then because she was making good progress. She commented that she realized, looking back, that it was the same issues over and over again that were bringing her back into counselling.

Arlene said, "I'm really aware of the time pressure, though." Knowing she only had until April to get done what she needed to do in therapy affected her, made her have to focus and not engage in distracting or "dancing away from painful stuff." She was able to use that pressure constructively.

The ability to do so may have related to the fact that she had a great deal of experience with therapy, "that's 12 years of experience," she told me. For Nathan, even the time limits on the length of individual sessions affected what he revealed, discussed or worked on in therapy, "...there's a whole lot of things around it (an issue he knew he needed to deal with but had not fully revealed to his therapist). And involved in it. And when I have opened up about that, it's been helpful, but it just – the whole thing. I can't do it all in an hour is part of it."

II. Bridges: Opening the Road to Progress

The most positive aspect of the research interviews was hearing from participants – mostly spontaneously – what had been helpful in therapy. They identified a variety of techniques and approaches they found helpful. They pointed out therapist actions that facilitated progress and therapist qualities that made a positive difference. They also shared the ways they worked to get the most out of their own therapy. Part II is dedicated to these findings.

A. Ways Therapy Helps

This section draws on the experiences and perspectives of the participants to illuminate positive experiences that occurred in therapy, positive steps that therapists took which helped them get more out of therapy, and positive strides that they made in therapy. In terms of client actions, I have focused mainly on actions that run counter to some of the behaviours that serve as roadblocks in therapy.

First I will look at experiences participants identified as being positive and helpful in therapy. Next, some of the beneficial qualities or characteristics of therapists will be considered. Lastly, I will explore ways participants helped themselves, "pushed their own envelopes," so to speak.

1. Positive Therapeutic Experiences

There have been a number of findings that surprised me in this research process. One significant one was how highly participants spoke of many of their experiences in therapy. In a way that paralleled their own persistence, they appreciated when their therapists were persistent and kept

trying different things until they found what worked for each individual. It meant a great deal to them to feel safe, accepted, understood and cared for. It was easier to benefit from therapy then. They also drew on their own inner strength to maximize their progress in therapy.

Feeling Safe in Therapy. One experience that made therapy effective for the participants in my study was when they felt safe with their therapists. Debora told me she is much less self-critical in therapy than in other contexts because "the therapy relationship is like a lot safer." What helped her feel safe and trust her therapist was "the experience of telling him things and not feeling judged..." Arlene was expecting judgment from her therapist, "And that's not what happened. And when he consistently disappoints me by not judging me." But she went on to say that it deepened the intimacy of their relationship.

Nathan agreed on that point. In our follow-up interview, he told me that in therapy, he would bring out and verbalize exactly what his self-critical thoughts were. When he did this, he was able to counter and/or dismiss them. Saying them out loud made it easier to see the unreasonableness or unfairness of those self-critical inner messages. "... I mean, I'm safe to bring it forward here." Arlene's therapist told her, "So if something doesn't work, you need to tell me. And I told him that day, and I really meant it. That okay, I won't, you know. If it's not working for me, I'll tell you." She indicated her past years of therapy helped her feel strong, secure and safe enough to let her therapist know when something was not working for her.

One important aspect of feeling safe was feeling safe enough to be honest. Arlene shed some light on this when she said, "I mean, he knows some of the horrible secrets about me and I don't feel at all rejected." Feeling safe enough to be honest sometimes meant, as with Arlene, that a person felt able to let his/her therapist know when something was not working. Other participants made comments that were consistent with what Arlene said about not feeling rejected. They felt they could tell their therapists things without fear of rejection or ridicule, they could express their feelings safely, and they could be more fully honest about their own

insecurities and foibles than they were able to be with other people in their lives.

It appeared that part of what contributed to participants feeling safe in therapy had to do with feeling *supported* by their therapists. When their therapists responded to them in ways that communicated support and understanding, the relationship grew and participants felt safer. Nathan: "Because then it was an obviously an extremely emotional time. And it was basically a case of, she was there, she was supportive. She was, I mean, she was sort of what w- sort of what was missing elsewhere as far as that kind of stuff went, and it sort of made me trust her a little bit more..."

Feeling Understood. Another helpful experience participants talked about was feeling understood by their therapists. This happened in many different ways. Sometimes it happened when a therapist judiciously used her/his own experience. Jenna: "She (the therapist) had some things in her personal life that she can, that she was very gracious in sharing even just a portion of it, just to say, 'well, yeah. I've experienced that idea, too.' So, I think she knew where I was coming from." Arlene felt understood when her therapist normalized her experiences for her, and when he listened to her feedback and adjusted to work at her pace. Similarly, Nathan felt understood by his therapist from the way she worked with him, "She seems to have realized that I'm a rather unstructured person, um so, everything's kind of unstructured."

Participants' comments also suggested to me when they felt their therapist understood their goals that strengthened the relationship. It was *helpful to support clients to identify or define and then review their goals* during therapy. One way therapists showed they understood their clients' goals was when they redirected them back to relevant topics, when participants had started off in another direction. Nathan felt understood by his therapist because she seemed to him to recognize that he needed to work on his goals in "small bites, and I'm not quite up to taking on the whole thing yet." Well-directed questions from therapists were helpful in communicating an understanding of client goals, and as Paul described, "I

didn't really feel like he was prodding me on. It was just more kind of ... uh, setting me in the right direction." Arlene observed of her therapist, "...I don't think he's ever specifically called me on it, but he has redirected when I've tried to distract."

Feeling understood by one's therapist went a long, long way in a therapeutic relationship. For example, a former therapist of Debora's acknowledged her sensitivity to interpersonal cues and helped her reframe that, rather than dismissing it. She said, "So that's why I kept seeing him even though he was crazy, for quite a while." He understood and accepted as valid an important aspect of herself, so she chose to keep working with him. It seems to me that feeling understood helps clients have faith that their therapists will be able to help them.

Experiences Normalized by Therapist. A number of participants identified how helpful it was for them to have their experiences normalized for them by their therapists. Debora found it somewhat comforting to have her therapist frame some of her depressive symptoms as normal ups and downs that people go through. It was also some relief, "...the fact that he's not panicked about it helps me to be less panicked about it." When Jenna's therapist shared some of her own personal experiences, "it made me go, 'you know, I'm not totally alone. Life sucks to everybody once in a while.'" It seemed as if one implicit message participants got when their experiences were normalized was 'I'm not as flawed or abnormal as I thought I was.'

New Insights Gained. The ability to view oneself or one's problems from a new perspective was identified by a number of participants as a very helpful aspect of therapy. Sometimes it was a question the therapist asked that kind of startled the client into a changed perspective. Sheila helped me see what happens, "He'll catch me on stuff like, 'when you say 'that bad.' And I'm like, Oh shit! (Laughs). Wasn't really that bad. Why did I say 'that bad'? And then I'll have to stop myself and think about why I said 'that bad.'" Jenna explained it this way, "...she kind of helped me, moved me to a direction where I can kind of see things a little bit differently."

Paul pointed out that even when his therapist said something that he disagreed with, it got him to think, which was be helpful; "...Like when he says, what do you want to say to it (death)? Well there's nothing really I can say to it. It's... but it still, it kind of gets me thinking about it. Still gets me kind of...so that's good." He also described how sometimes the meaning of what was said or explored in therapy comes later for him, "...then maybe an hour after, maybe a week after, you know. But then I kind of think about it and I kind of put it all in a nutshell, so to speak."

Surprisingly, some of the participants identified watching tapes of their sessions as helpful. Jenna asserted, "I totally think that watching these, watching this is helpful. (Laughs) Because I kind of look at it and – like, it should be part of therapy. I'm sorry, I really think that it has to be a bit of a part – because when I look at this, I go, 'I'm rehashing it again! Why?! I've been there, done that!'" She also realized some of the progress she had made from watching her tapes. She commented on how it showed where she had been compared to where she perceived herself to be now.

Receiving Positive Evaluation. Participants seemed to engage in two contradictory behaviours at times. On the one hand, they sometimes tended to minimize and discount signs of progress and positive feedback from their therapists. Yet at other times, they were really impacted by their therapists' positive evaluations of them. Noting client accomplishments was particularly effective when there was a strong therapeutic bond and a sense of trust in the therapist. Debora explained it this way, "Well, actually I, I like it (receiving positive feedback from her therapist). (chuckles a bit). I mean, it's very positive for me. *Um, I mean, with some other therapists, I might have, I might feel like they're just making it up and you know, that it's not really true.* But, I actually trust Fabian quite a bit. So I believe him. So it's very reinforcing and very affirming" (italics added). What is also fascinating is that if she felt the affirmations were coming from a therapist she did not trust, she would have dismissed them!

Amber's therapist would call her to give her positive messages about herself, and over time, Amber came to recognize these herself; "Like, if it's

just because I'm making smarter choices or – like I'm , if it's the actual therapy that like, maybe I'm realizing a lot of things about myself and I'm handling myself a lot better." Arlene found that sometimes when her therapist noted her accomplishments, it gave her pause. She would stop herself and take it in, working at not dismissing and discounting it. She found doing so gave her a profound feeling of delight.

Receiving Validation. Debora told me "...I've had good therapy and bad therapy. And when it's not good, I leave." Yet she continued to work with a counsellor whom she described as "crazy." One significant reason she seemed to suggest was because he validated a belief about herself that other therapists had tended to discount and dismiss. She said, "...it was just the idea that he um, actually could see who I was."

This theme of the importance of being validated in therapy came up with other participants as well. Arlene also commented during our interview, on a moment when her therapist validated her by supporting her opinion. She felt like he did not judge her right then, as she was expecting, and as a result, the intimacy of their relationship was deepened for her.

Sheila described how she would check with her therapist about things happening in her life or her reactions to them, "And I've asked Ben if I'm totally out to lunch." When he normalized her reaction and validated her perspective, "I'm like (sighing), 'Alright. Well then, I feel better.'" What seems to be important in the examples from these participants is that their thoughts, beliefs, experiences and reactions were treated as real and valid by their counsellors.

Other Helpful Interventions. Participants in this research identified many different helpful interventions. There was no type of interventions or kinds of interventions that particularly stood out as being uniquely effective with very self-critical people.

Not surprisingly, simply being listened to was helpful. Debora described her therapist thus, "...he listens and he's very empathetic. And I have to say, that's kind of amazing." Amber said, "I just need to like, talk to somebody about whatever went on or whatever I'm feeling. It's like I don't

even want an answer. I just need to get some stuff off my chest." Ishmael appreciated being challenged by his therapist. Other participants indicated valuing being redirected by their therapists when they believed they were getting off track in therapy. Arlene said, "...he's reframed things. What I've found most helpful with Calvin is the questions that he comes up with... he does ask reframing questions, and that helps me."

Debora and Arlene identified the benefits of being able to express and process emotions in therapy. Arlene, "...He's let me do a lot of really painful crying. I can't believe how much I walk out of here crying. I'm not much of a crier. Well, I hadn't been up until the last year." Paul noted that sometimes his therapist's prompting him to search for his feelings helped him uncover feelings and experiences he was not aware he was having.

Various participants commented on how they appreciated when their therapists continued to try different things, to figure out what would be most effective. It seemed like that trying different techniques communicated caring and respect for the client as well as a genuine desire to really help the client. Jenna had this to say, "...her technique of trying different things all the time. Let's try this. Okay, that's not working. Or didn't work so well. Let's try this. Okay that works a little bit better. It was totally helpful. Made a huge difference to me." Sheila appreciated that her therapist would slow her down and help her become more aware of how she was being impacted by events in her life. Jenna shared that although it had been awkward at first, her therapist had used music in a beneficial way in therapy.

Nathan and Jenna identified that it was helpful for their therapists to explore SC with them; to help them recognize it and see how it was affecting them. Nathan shared that, "...it's definitely something that's being worked with. It's not being worked around, which is very good." He went on, "...I'm just, I'm doing it, and it's – and I'm letting the self-critical parts come out and we're just dealing with them as they come..." In fact, several participants found the research interview quite helpful and insightful for the very fact that it highlighted the presence of and problems they were having

with SC. Participants identified many different kinds of therapeutic interventions as helpful, including the use of a two-chair technique (or a written variation of that), journaling, reframing the client's situation, having the therapist maintain a positive attitude, use of imagery, focusing, relaxation techniques, stopping distractions and redirecting, refocusing, allowing emotional expression, conveying empathy, being present and responsive to nonverbal cues, acknowledging therapeutic errors (e.g., Arlene said of her therapist; "He acknowledged it. He acknowledged that he'd made a mistake and hadn't realized it, and okay, let's do this. So he went with my direction. He didn't fight me at all."), clarifying goals, practical, down-to-earth techniques to use at home (Debora gave this example; "... her advice on how to parent (my daughter) was just invaluable because I was having so much trouble with her, and you know, she could have really become like a problem child at school, you know. But we kind of cut it early on."), and therapeutically relevant and helpful use of self (e.g., Jenna revealed that having her therapist share some of her own personal experiences helped her feel less alone in her experience). Individuals who are very self-critical appear to benefit from many of the same types of relationship aspects and interventions that less self-critical people do.

2. *Positive Therapist Qualities*

The distinction between interventions that the therapist "does" in therapy and the relationship aspects may be mostly an artificial one. Creating a sense of safety and a nonjudgmental atmosphere, for example, tends, in my view, to go together with treating the other with dignity, care and respect. So there is necessarily some overlap here. Communicating to one's client care and respect for him or her comes both from what is done and how. There were two main ways I saw in my interviews that the therapeutic relationship contributed to positive outcomes for clients. Broadly speaking, it is important that the therapist communicates caring for the client, and demonstrates an investment in the relationship.

Therapist Cares. One of the most touching discussions for me of the therapist showing caring came from Debora: "...once, the first time that I

cried in therapy, um I noticed that like, he was almost emotional, too. Like, not inappropriately so, but I could tell that he was like really empathetic. And that really made an impact on me, you know. So, I felt like, you know, I kind of feel like he's in my corner." The simple act of allowing the client to see that she had an effect, a genuine emotional impact on her therapist, was a powerful moment.

Nathan found that being supported through a very difficult emotional time, without any sense of judgment or ridicule helped him build trust in his therapist. It also seemed to me that a therapist's effective responsiveness to his/her client communicated caring. For Arlene, this was demonstrated when she asked specifically for an increase in the number of sessions, and her therapist respected that request and agreed to it.

Sheila commented that she felt her therapist really cared about her; he was not just doing his job, in her opinion. As mentioned earlier, Debora had seen evidence that her therapist was emotionally impacted by her and what she was experiencing. That meant a great deal to her. What is being invested in a relationship? Therapists showed participants they cared about their relationship when they gave a genuine response to questions from their clients like, "What do you think about that?" Another way therapists demonstrated care and respect was by being open to receiving honest feedback from their clients.

Ishmael was perhaps most vocal in identifying how much he appreciated directness from his therapist, but he was not alone. Being open to corrective feedback from a client says that the therapist care enough to hear his/her concerns, and is willing to make changes both for the sake of the therapy, and also for the sake of the relationship.

B. Ways Clients Help Themselves

There were many positive actions that participants engaged in that seemed to contribute to their growth and improvements in therapy and that to a degree counteracted and neutralized some of the effects of SC.

Allowing Discomfort. Participants seemed to recognize the need to be able to tolerate some discomfort in session. Sheila commented on how

powerful the experience of a two-chair technique had been, as well as how uncomfortable she had been switching chairs. Jenna decided and understood that she needed to cope with the discomfort of potential shame and embarrassment in order to be honest with her therapist. She felt she had to be that honest, no matter how uncomfortable, if she was going to benefit from therapy the way she wanted to. Arlene commented that she had come to the belief that if there was no pain in therapy, it was not working.

Being Less Self-Protective. Closely related to tolerating discomfort was the ability participants sometimes showed of being less guarded and self-protective in sessions. As had been discussed earlier, an impediment to the therapeutic process was when participants "hid" significant issues from their therapists partly out of fears of judgment and rejection. By contrast, sometimes participants made conscious choices to take risks and be vulnerable in therapy.

Two participants, Nathan and Jenna, advised me that with their present therapist, they had made the *conscious decision* to be as honest as possible, to face and name what they wanted to hide in spite of their fears of rejection, ridicule or censure from the therapist. Both Nathan and Jenna chose to do this from the belief that this would help them improve faster, and in their view, it did make a difference. Jenna said, "...when I walked into the counselling, I told myself, I'm not going to be on guard. I'm going to say things, that even if I'm ashamed of them, or whatever, I'm going to say them."

Paul noticed that talking about things in therapy helped him be more open in other relationships; "Yeah, because ... well, like I can talk about them here and then kind of think about them and realize, well, oh, that's not such a big issue, or oh, somebody – this person really knows about something like that, maybe I should ask him..." In that way, therapy helped him be less guarded and self-protective in his interactions with others.

Noticing One's Own Improvements. While there were many times when participants were inclined to discount, dismiss or ignore their strengths, positive attributes and evidence of improvement, there were other times

when they did acknowledge these things. Referring to that self-critical inner voice, Nathan observed, "It doesn't seem to need to be there in the background as much. Or if it is in the background, it's more easily, easy – I'm more able to dismiss it quicker."

Arlene noticed that when her therapist pointed out some accomplishment, and she stopped herself from ignoring or dismissing what was said, "...there's this really pleased feeling. It's like a delight. Like it – or a treat! ... There's a feeling of delight." Nathan was surprised to realize he had been in therapy only a few months. "...It almost feels, like it's been more than that. Because it just – I don't know. I – maybe I'm making progress at a more rapid pace than I expected."

Persistence: Not Giving Up. I was struck by participants' persistence on many levels, in the face of many real and perceived stumbling blocks. The most obvious, of course, is their sheer determination in continuing in therapy – in a few cases for years – until they felt better, until they had accomplished what they set out to. Most participants had wanted, needed or been forced by circumstances to change therapists at some point. The majority of them could give examples of bad experiences they had had in previous therapy. Yet they did not give up on the idea of therapy, that it could be helpful for them if they just kept trying. They did not give up on the idea that they could feel better, solve their problems or get over their past.

Jenna showed another type of persistence in her decision to try a different approach with her present therapist. She looked back at previous experiences, decided there was something she could do differently (i.e., risking being honest with her therapist), and did it. Debora, too, looked at what she could do to improve what she got out of therapy. (Perhaps this is where evaluation without criticism or judgment, might be beneficial.) "I said to him, oh, I think I brought up a lot of pointless things, you know, that didn't really get at the heart of my problems." She thought over her sessions and decided there were other things she needed to bring, and wanted to take responsibility for "chatting" rather than talking about her problems, which she owned was easy for her to do. Arlene and Ishmael described how they

came to therapy ready to work. These, to me, are all demonstrations of persistence and determination to make therapy effective.

Advocating for Oneself. Some of what participants talked about and described sounded like ways in which they advocated for themselves. Occasionally, this was evidenced in participants changing therapists. Debora indicated being quite willing to change therapists if she thought she was not going to be able to work effectively with the person, and had done so on more than one occasion.

Arlene advocated for herself in at least two ways in therapy. She advised her therapist she needed to see him more often when she felt that was required in order for her to accomplish what she wanted. She also gave him honest feedback when something in therapy was not helpful or effective. Debora, in addition to changing therapists when she felt she was not getting what she needed, was also "...very persistent about trying to kind of track that (an important issue) down and being, um, argumentative, as I said, you know, kind of just to try and get to the bottom of what's going on...So, the more argumentative I am in therapy, the more I get out of it in the long run."

Nathan advocated for himself when a suggestion or intervention did not work for him. As a culmination of her therapy experiences, Jenna vowed to advocate more strongly for herself in the future when finding a new therapist. She said, "Like I'll go a couple of times, and I'm like, no, this, this just isn't – there's no connection happening, I'm going to say, I'm sorry, but I want to see someone else."

Turning "Off" Inner Critic. An interesting phenomenon that I think contributed to more positive outcomes was the ability of some participants to "turn off" their inner critic in some situations. Debora, for instance, said that when she was focused on something she wanted to say or a point she wanted to make, she would not be engaging in self-criticism. She and Nathan both reported being <u>less</u> self-critical in therapy than in other situations. This was partly due to them feeling very safe in therapy. Paul reported engaging in a lot of evaluation before he said something, but not

worrying about that after it was said. In contrast, Jenna said, "So I think that whether I'm fortunate in the fact that, or a fool or whatever, if there's a difference, is I'm able to live in the moment and I'll feel bad later."

Other Positive Coping Behaviours. There were a few other positive strategies used by the participants. Jenna and Debora could watch themselves and find the humor in some of their foibles, to laugh at themselves a little. Arlene had discovered the need to be able to tolerate pain, "Being upset might be useful. Right? Being in pain might be useful. So, I've got a different opinion of the therapeutic process than I did a year ago, because if it isn't painful, it isn't working, right?" Maintaining a sense of humor and being able to tolerate pain seem like they would help an individual be able to experience more success in therapy. A good-humored laugh at one's "neurotic" behaviour rather than mercilessly berating oneself seems much more adaptive and potentially helpful in the long run. Nobody is perfect, so it is beneficial if one does not have to take all of one's small foibles so seriously.

III. The Experience of Participation

Negative Reactions and Experiences

There were a number of issues that I noticed were directly related to participation in this research. First of all, watching the tape seemed to elicit many self-critical comments from participants. They were critical of their appearance as well as their words. To some degree, I think this is a relatively common response to seeing oneself on videotape. Additionally, the focus of watching the tape was to watch their reactions and talk about interactions, inner experiences and feelings. This could have heightened participants' awareness of themselves. None-the-less, a positive comment from a participant was rare, while disparaging remarks were common.

Upon watching themselves in session, a frequent critique from participants was they had not done a 'good enough' job of saying what they wanted to say during therapy. They felt they could have said things better. Paul, for instance, observed that previously he had believed he had done a good job of explaining his thoughts. But after watching the tape, he

commented that he could have said things much more succinctly. At times, participants were critical of what they talked about in session, not only how they discussed it. Several also expressed concern that the research interview might be a waste of time because they did not know what they would be able to contribute to my research. A few participants also said they were aware during their therapy session that the tape was going to be reviewed during our research interview, so they were somewhat cautious in what they brought up and dealt with in that session.

Watching the tape was anxiety-provoking for some participants. Nathan was the most obviously uncomfortable participant. He anticipated the tape-watching to be quite an awful experience, which reminded me of a common self-critical tendency to expect negative outcomes. He was not the only one to participate despite some reticence. There was perhaps an altruistic aspect, in that he and Jenna participated in spite of reluctance, in the interest of helping others (me as well as future clients). However, there was also a level at which they seemed to be discounting or dismissing themselves and their own needs and comfort. Jenna participated in the research with the hope that, "...eventually, in the end, I'll get something, whether it's – I'll get the person's respect or likeability or something. I'm doing this for... there is an underlying, that there will be some benefit to me..."

Nathan also commented in our research interview that he felt like the "guinea pig" and I was the one in charge of the research project. He did go on to say that he believed there was a "level playing field" between us, especially because the interviews took place in 'neutral' territory. He perceived that the Clinic was neither his nor my 'territory', so having the interviews there contributed to a sense of equality between us. Jenna described my role more as the "overseer," kind of checking to see if therapy was working or not. She also added that she thought it would be helpful for her therapist to check on progress in a similar manner.

Positive Reactions and Experiences

There were some very positive outcomes related to participation. First, most but not all participants reported finding the tape review and discussion a helpful process. They also appreciated that the research interview gave them a chance to review how therapy was going for them. They reported being able to see themselves and their problems from a new perspective. One participant sent a message to me that she had experienced a deep sense of empathy for herself – rather than the usual judgment and criticism – as a result of watching the tape.

Notwithstanding some reluctance to be there for the research on that particular day, Jenna stated quite strongly that she felt therapists and clients should regularly review tapes. Jenna told me she thought the IPR portion of our interview was very helpful and that she got a lot out of reviewing the tape of her session. She said it made her progress and positive changes more obvious to her; "when you see someone on a daily basis, you don't realize how long their hair gets. You don't realize subtle changes. Because this is, it's a process, and it's subtle changes all the way through, you don't yourself notice how you're, how you're growing as an individual." She and others were able to use the tapes as a way to highlight their progress and see changes they had made since they began therapy.

A number of participants commented on how helpful and thought-provoking it had been in the research interview to be asked about their self-critical tendencies. This had not often been identified and/or addressed during therapy. Arlene stated, "...as the interviewer, you offered quite a lot as you went along. And you gave me a lot of information in terms of the evaluation, perfectionism, its impact in some of the counselling sessions." This will be addressed much more thoroughly in the following section. Nonetheless, clearly self-criticism needs to consistently be identified and 'treated' in therapy.

As I conclude this section, I want to highlight just how intense and challenging it was for the people who participated to be involved in this research. As noted in my Methodology chapter (see Chapter 3), all of the

participants were selected because they obtained high scores on the SC scale of the DEQ. Being very self-critical tends to involve the following (taken from Dunkley, Zuroff & Blankstein, 2003): "constant and harsh self-scrutiny, overly critical evaluations of one's own behaviour, an inability to derive satisfaction from successful performance, and chronic concerns about others' criticism and expectations" (p. 234). While I believe parts of the research interviews were relatively non-threatening (e.g., phase One, where participants answered general questions about their experiences in therapy), other parts involved watching and discussing extremely intimate and personal events with a near-total stranger. Many people are at their most vulnerable during individual therapy sessions. People are often less guarded and more likely to divulge personally painful or traumatic events in therapy. Participants did have the advantage of knowing that their session was being taped and that they would be reviewing it with me. None-the-less, this was in my opinion, a very high-risk event emotionally. How hard it must have been for people already prone to negative self-evaluation and self-scrutiny to watch tapes of themselves in therapy. In a way, the research process provided an environment that was ripe for engaging in SC. In spite of this, most participants told me they enjoyed participating and found aspects of it useful therapeutically, as well!

CHAPTER FIVE
DISCUSSION

Overview of Findings

Before discussing the implications of this research, I will briefly recap the major findings of my research. There were two over-arching themes that emerged from a thorough analysis of the interview data; 'Road Blocks' and 'Bridges.' 'Road Blocks' refers to the many ways in which self-criticism (SC) subverts, distorts and interferes with the therapy process as experienced by these participants. Despite these difficulties, all of the participants expressed finding some benefits from and often major commitment to therapy. 'Bridges' refers to the positive aspects of their therapeutic experiences, especially the way in which they and their therapists were addressing and alleviating the interference of their SC. After concisely reviewing my findings, I will discuss their relationship to therapy and the impact they suggest SC has on it. Recommendations for working with self-critical clients will be outlined. I will conclude with comments on directions for future research, limitations of the present work, and a final brief summary.

Road Blocks

Under the umbrella of the 'Road Blocks' theme were the myriad ways self-criticism manifested itself in the participants and in their experiences in therapy. The eight individuals who took part in this research appeared to have a self-critical approach to life at that time. Most of them openly admitted that they were almost constantly evaluating and criticizing themselves. They had very high expectations of themselves, and were much more likely to find fault with themselves than to notice their assets and abilities. Sometimes these high expectations were also imposed on others. They also evaluated their therapists and their therapy experiences.

The participants appeared to expect judgment and rejection from others. They expected things to go badly. When things went well, they worried and wondered how long it would last. In addition to expecting judgment and rejection from others, they did not easily receive

compliments, including from their therapists. They approached positive feedback with far more suspicion than negative feedback. They tended to minimize and discount both their accomplishments and their needs.

Participants had a generally self-critical approach to relationships as well. They sometimes felt misunderstood – it seemed to be more by previous therapists than their current ones. They revealed a view of themselves as flawed, and messages from their social networks – as interpreted by the participants – tended to reinforce that view. Trusting others was difficult for them. Sometimes their need for approval from their therapists interfered with their ability to openly identify and address problems. Several of the participants were very aware of issues of rank and power. Help from a therapist who was perceived to be of a lower rank than the participant was at risk of being dismissed as lacking value or worth. Most times, an equal relationship, a level playing field was the preferred dynamic for the therapeutic relationship.

Fears of various kinds became another theme among participants. In their research interviews, the participants revealed some of the fears that affected their actions in and experience of therapy. Perfectionism and a fear of failure were evident for some. Shame as well as a need to maintain control of themselves, of their emotions and their experiences sometimes kept participants from revealing important problems that they believed needed to be addressed in therapy. Participants also used avoidance as a coping strategy. Coping with problems by avoiding has been linked to depression (e.g., see Yapko, 1997; 2006). Participants engaged in self-protection by avoiding painful topics, containing (not expressing) their emotions, and choosing their words very carefully.

Nearly everyone in this study shared some previous experience in therapy that had been harmful and upsetting for them. When a therapist said something that seemed judgmental or when s/he would refuse to give the client honest feedback or advice, participants felt unsupported and uncared for. Careless comments also had the potential to undermine participants' self-confidence and to destroy hope. Lastly, a significant

situational impediment was the limitation on the length of therapy participants could receive. Most of the participants had been in therapy before and simply put, brief therapy was just not going to "cut it." The issues they faced were long-standing and difficult to ameliorate.

Bridges

The participants had many positive, hopeful things to say about therapy, which have been outlined in a section called 'Bridges: Opening the Road to Progress.' They identified a number of very significant factors that enabled them to benefit from therapy. Some of these related to the therapeutic context, others specifically to the therapist. Feeling safe and understood were important aspects of therapy for the participants. They expressed how greatly they valued having a therapist with whom they could feel safe enough to be open and honest. It helped a great deal when they were made aware that they were not alone in their struggles and they were not 'crazy.' When therapists saw them for who they really were, they were able to take more from the therapy. The participants also appreciated when their therapists did not treat them as if 'one intervention fits all.' They valued being able to say when something was not working for them and having the therapist respond by trying something new. Participants noticed when their therapists gave the message that they cared about them, and when therapists communicated that they were invested in the relationship.

Another significant finding was that there were many things that participants themselves did that counteracted their self-criticism or helped them get more out of therapy. They were realistic enough to allow for some personal discomfort from the therapeutic process. They recognized that an uncomfortable intervention could still be helpful. They sometimes took risks; for instance, risking honesty about deeply painful or shame-producing experiences or topics. They sometimes could recognize and celebrate signs of progress and success, as well as occasionally noticing the benefits they were obtaining from therapy. One striking finding was how great their persistence was in the face of previous negative therapeutic and life experiences. Participants who advocated for themselves and what they

needed also got more from therapy. There were also times when some participants could turn off their inner critics and be less self-critical in specific contexts, most notably in therapy.

In the coming sections, I intend to place my findings in the context of the larger body of research on self-criticism, as well as considering their relation to several other pertinent fields.

Self-Criticism and Therapy

Self-Criticism as a personality trait has been intensively studied (see Blatt, 2004) and a number of research projects examine the effects of this SC on the process of therapy (e.g., Blatt, 1999; Blatt, Quinlan, Pilkonis, & Shea, 1995; Blatt & Shahar, 2004a, 2004b; Blatt & Zuroff, 2005; Blatt, Zuroff, Quinlan & Pilkonis, 1996; Blatt, Zuroff, Bondi et al, 1998; Layne, Porcerelli & Shahar, 2006; Shahar, Blatt, Zuroff & Pilkonis, 2003; Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004; Whelton, Paulson & Marusiak, 2007; Zuroff, Blatt, Sotsky et al, 2000; Zuroff et al, 2007). What none of these studies have done is examine the experience of highly self-critical people while they are in therapy. Furthermore, none have interviewed self-critical clients directly, to hear firsthand about their experiences in and of therapy. This study has done so and much of what was learned from participants serve greatly to solidify, clarify and extend what is already known. After recapitulating briefly what has previously been found, I will describe how my findings serve to extend what is currently known.

The very self-critical person engages in near constant, harsh self-evaluation and self-scrutiny (Blatt, 2004; Blatt & Zuroff, 1992). Fears of disapproval, loss of respect, and rejection are common (Mongrain, Lubbers & Struthers, 2006), as are feelings of guilt, unworthiness, inferiority and failure. Successes and accomplishments are rarely enjoyed or even fully acknowledged (Blatt, 2004). People who are very self-critical are often also less agreeable than the average person (Dunkley, Blankstein & Flett, 1997). They may be less willing to be cooperative in relationships (Santor & Zuroff, 1997; 1998), less loving, more hostile and quarrelsome (Mongrain, Vettese, Shuster & Kendal, 1998; Zuroff, Moskowitz & Coté, 1999), and have a

negative attribution style (Shahar, Trower, Iqbal, Davidson & Chadwick, 2004). They may use maladaptive coping strategies such as self-blame and avoidance (Dunkley & Blankstein, 2000). They are often self-denigrating and negative in social interactions (Vettese & Mongrain, 2000).

People who are very self-critical seem to elicit more than normal amounts of negative feedback from others, which likely contributes to their negative self-views and their perceptions of having weak or poor social support systems (Zuroff, Moskowitz & Coté, 1999). In addition, research in the area of self-definition (see for example, Giesler & Swann, 1999; Swann, Bosson & Pelham, 2002; Swann & Pelham, 2002; Swann, Polzer, Seyle & Ko, 2004) suggests that people in general gravitate towards others who see them as they see themselves. They will actively work at getting others to view them in ways congruent with their self-views. In this regard, very self-critical people are no different from others. They gravitate towards others who hold a similar negative view of them, and work to "correct" a view that is felt to be unduly positive and therefore inaccurate.

The findings of this research suggest that the self-critical individuals who participated showed the common hallmarks of SC in therapy just as self-critical people have been found to show in other contexts. Previous research has not often identified what kinds of processes were occurring with self-critical people while in therapy. As such, this research extends what is known about self-criticism in the therapeutic context. The discussion of the findings and the implications is divided into five sections; (a) near-constant negative evaluation of self and process, (b) negative or unreasonably high expectations, (c) shame and fear of rejection, (d) the central importance of the therapeutic relationship, and (e) the need for time.

Constant Negative Evaluation of Self and Process

Two of the most significant aspects of a self-critical personality style are engaging in ongoing evaluation and being harshly critical of oneself. These were present both during the therapy sessions that I watched with participants as well as during our interviews. Being preoccupied with ongoing evaluation, self-scrutiny and criticism can keep a person from being

completely absorbed and involved in therapy. Several participants shared that they were constantly evaluating themselves and what was happening in therapy, and acknowledged that this interfered with their full participation in the process.

These internal behaviours had the potential to undermine the beneficial effects of therapy. In other words, the tendency for participants to evaluate and criticize themselves extended to the therapy setting. This is consistent with the literature that shows that very self-critical people engage in ongoing criticism and self-evaluation (Blatt, 1999, 2004; Blatt & Zuroff, 1992; Powers, Zuroff & Topciu, 2004; Shahar, 2006; Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004; Zuroff, Blatt, Sanislow, Bondi & Pilkonis, 1999; Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow & Simmens, 2000) and buttresses the argument that self-criticism is a very enduring personality trait (Bagby, Shuller, Parker, Levitt, Joffe & Shafir, 1994; Blatt, 2004; Blatt & Zuroff, 1992; Cox, Rector, Bagby, Swinson, Levitt & Joffe, 2000). These findings also imply that part of the reason self-critical individuals do not improve as much as they might from therapy is due to the fact that they are likely engaged in harsh criticism and negative evaluations of themselves and their progress in therapy.

Powers, Zuroff and Topciu (2004) discovered that people may engage in self-criticism that is overt or internalized. They (see also Shahar, 2006) suggested that individuals may engage in overt self-criticism as an 'impression management' strategy. That is, they make self-critical statements which are intended to "elicit support and avert criticism from the interpersonal environment" (p. 69). Participants in my research engaged in both overt and covert (or internalized) SC. At least one participant acknowledged overtly criticizing herself in the hopes that someone else would not. She expressed a belief that her own criticism would be gentler or easier to cope with than the criticism coming from another person. This research provides some support for the hypothesis that individuals engage in overt SC in order avert criticism from others.

The tendency for participants to evaluate was evident in many areas of therapy. They evaluated their use of the session time. They were

frequently critical of what they had chosen to talk about, and wondered if it were the topic that most needed to be dealt with. They questioned whether or not they had said things as well as they could have. They asked themselves if they were avoiding issues that they should be dealing with. If so, why? The evaluations and self-criticism were also accompanied by high expectations, especially of themselves. What the participants shared illuminates the kinds of negative self-evaluations very self-critical clients may engage in that contribute to poorer therapeutic outcomes.

The results also suggest that participants' self-critical messages were sometimes being reinforced by negative messages from significant others in their lives. For example, one participant explained how his partner believed 'only crazy people need counselling.' Once again, we see how these results help confirm what has been theorized about SC, and complement what has been found in other research. Blatt and Shahar (2004a) observed that SC impeded therapy because it interfered with the development of interpersonal relationships both within and external to therapy. Mongrain, Lubbers and Struthers (2004) demonstrated in their research how the social environments of self-critical individuals were often a source of criticism and rejection. The results of this research demonstrate the possible mechanisms through which an individual's social support network could undermine the effects of therapy. That is, my findings lend some strength to the hypothesis that negative relationships outside of therapy impinge upon the progress that is being made in therapy. Thus the negative effects of SC on therapy may be partially mediated through social support systems (Powers & Zuroff, 1988; Shahar, Joiner, Zuroff & Blatt, 2004).

The participants in this research were typically self-critical in that they tended to minimize and discount some of the positive feedback they received from their therapists and some of the evidence showing the progress they had made. Thompson and Zuroff (2004) noted that 'success' for someone who is very self-critical is often a "moving target." The standards keep moving higher. This appeared to be the case for participants, even in therapy. There was a puzzling dialectic among participants of sometimes

wanting and appreciating positive feedback from their therapists, while at other times dismissing and ignoring that. These findings strengthen Beck's (1983; see also the work on attribution theory by Abramson, et al, 1989) contention that sometimes depression can occur when an individual is predisposed to interpret events in a negative manner. Events that could be viewed as neutral or even positive – such as when one participant's therapist recommended less frequent therapy – may be interpreted and responded to as if they were negative. In this example, the participant reported feeling rejected.

Negative or Unreasonably High Expectations

Participants in this research revealed that, in harmony with previous findings about SC (Blatt, 2004; Blatt, D'Afflitti & Quinlan, 1976; Blatt & Zuroff, 1992), they had very high expectations of themselves. High expectations interfered with therapy because it sometimes led to participants/clients to expect to be perfect. Furthermore, participants expected a lot of themselves within therapy. For instance, one person commented that she expected to be making progress in every session. There was the implication that if she could not identify measurable progress, then she (and her therapist) had wasted the session. As mentioned in Chapter Four, it seems very likely that clients with such high expectations for themselves might tend to be disappointed with their therapy and with the amount of progress they felt they were making, no matter how much progress had actually been made. Therapy could become a source of disappointment and feelings of failure if the person believes she should be making more progress and faster. Clearly, a vicious cycle of failure and disappointment could result. Shahar, Blatt, Zuroff, Krupnick et al (2004) found that SC interfered with the development of the therapeutic alliance, which partially explained why very self-critical patients were not benefiting enough from therapy. Another partial explanation suggested by my research may be the inability of clients to recognize and appreciate their successes.

Along with high expectations of themselves, participants sometimes revealed high expectations of their therapists, and this too had the

capability to contribute to poor therapy outcomes. One way in which evaluations of the therapist had the potential to undermine the process was when a client felt the therapist was of a lower (social) rank or in a less powerful position than the client. Help, positive feedback, and suggestions were then more readily dismissed. Yet at the same time, generally, participants did not want their therapists to be authority figures. It seems there would be a fairly delicate balance of power, with the therapist easily tipping into much or too little power and losing credibility and effectiveness. Research with other therapy clients has led to the discovery that issues of rank and power can influence outcomes. For instance, a participant in Henkelman's (2004) research stressed the importance of minimizing the power difference between counsellor and client. One of Henkelman's participants reported that the significant difference in perceived power between counsellor and client was detrimental to her therapy.

Among the challenges to working with self-critical clients are the very self-critical individual's tendencies to anticipate future negative events and to find positive ones disquieting and uncomfortable. This can be partially understood through the work of Swann (Giesler & Swann, 1999; Swann, Bosson & Pelham, 2002; Swann & Pelham, 2002; Swann, Polzer, Seyle & Ko, 2004) and others on self-definition and self-views.

Self-critical people have internalized a negative view of significant aspects of themselves, of their relationships with others, and of their past, often with good reason – their views are frequently based on significant past experiences, relationships and events. Bowlby (1977) hypothesized that each person develops "internal working models" of him-/herself, others and the way the world 'works.' People who are very self-critical have developed negative models of self and others. Consequently, when they experience happiness and positive changes in their lives, it has the potential to be quite contrary to what they 'know' and expect about themselves and the world they inhabit. They may feel that a therapist who sees them in a positive light does not really understand them. They may work to 'correct' the therapist's

view so it more closely matches their own. Such actions would be consistent with what has been found by Swann and others.

In harmony with other research on self-criticism, participants often had what came across as a negative outlook on life (Dunkley & Blankstein, 2000; Mongrain, 1998; Mongrain, Vettese, Shuster & Kendal, 1998; Shahar & Blatt, 2005; Zuroff & Duncan, 1999; Zuroff, Moskowitz & Côté, 1999; Zuroff, Stotland, Sweetman, Craig & Koestner, 1995). They seemed to expect judgment and criticism from others, including therapists. At times, it was uncomfortable for them when they did not receive judgment. A few participants indicated, however, that when they had received judgment from a therapist in the past, it caused them to end the therapeutic relationship. One wonders if relationship ruptures both within and outside therapy are not more common among self-critical people than others.

Similar to individuals in other research (e.g., Hankin, 2006; Shahar, Trower, Iqbal, Birchwood & Chadwick, 2004), the participants tended to anticipate future negative events, which could have served to undermine progress in therapy. They were expecting negative outcomes in their lives, although not necessarily in therapy. Positive changes could be and were ignored and resisted, quite possibly in part because they were not what the participant had come to expect from life. Positive events evoked fear from some because they could raise expectations – their own and others'. Happiness once attained could be destroyed or taken away unexpectedly. Similar findings have been uncovered among insecurely attached individuals. Mikulincer and Shaver (2003) suggested that "...for anxiously attached individuals, positive states may quickly bring to mind other instances in which things began well but ended badly" (in Bartz & Lydon, 2006, p. 93). In a sense, an individual is working at cross-purposes in therapy if she comes in wanting positive changes and to feel better, but those very things evoke fear and avoidance from her. As one participant put it, very self-critical clients were lacking the "skill set to know how to handle happiness."

It makes some sense that an individual would avoid something that induces fear and discomfort, so the tendency of participants to minimize and discount themselves and their progress seems in a peculiar way an adaptive response to a negative stimulus. If progress creates feelings of dissonance, and a sense of being a 'stranger' to oneself, then not acknowledging progress or change would be a way of reducing discomfort. Still, we can see how SC thwarts the client's and therapist's efforts to create lasting positive change.

Negative expectations of others had the potential to undermine therapy in a particular way for participants. Sometimes, a therapist's attempts to normalize a client's experience were perceived as minimizing and discounting the client's problems or concerns. Feeling misunderstood by the therapist contributed to participants in this study feeling that therapy was not helpful. The importance of feeling understood by one's therapist is increasingly being recognized as facilitating positive change in therapy (e.g., Hubble, Duncan & Miller, 1999; Henkelman & Paulson, 2006; Paulson, Everall & Stuart, 2001). Feeling misunderstood by the therapist could lead to a client remaining focused on problems and ignoring successes in an effort to try to make the therapist fully understand him/her.

Furthermore, if someone is already inclined to expect judgment and criticism from others, it is easy to imagine how a therapist's efforts to normalize an experience could be negatively interpreted. Comments, reactions and events may be construed, understood and/or experienced by a self-critical client as more critical, judgmental or rejecting than the therapist intended. Therefore, ruptures might more easily occur and might be more difficult to repair. In fact, the therapist might never even have the chance to attempt to repair the rupture, because the client might just never come back, as was the case for several participants in this research.

It seems that there is a fine balance between communicating to a client that her/his experiences are normal and communicating a lack of concern for or a dismissal of client problems. That is, a therapist must strive to help clients recognize and take comfort from the fact that their experiences

are within the 'normal' limits without giving the impression that the therapist is not taking both the client and his/her concerns seriously enough.

For some participants, having negative expectations was less uncomfortable than being happy. Because happiness may have preceded disappointment or disaster in the past, clients who are very self-critical may be wary of it. As one participant in this study said, "...(doing better is) what makes me happy. It's just I'm nervous that it's gonna fall apart." Self-critical clients may expect happiness to end and may feel some relief when it does, because they no longer have to wait for that to happen. It is not only that self-critical clients might resist happiness or signs of improvement. As noted earlier, they may, due to their unreasonably high standards and expectations of themselves, fail to notice or minimize and discount the evidence to suggest that things are getting better. So, the therapist is faced with the challenge of noting accomplishments and providing much needed affirmations, but not communicating a lack of understanding of the client's problem, or a view of the client that is too divergent from the client's own self-view.

Shame and Fear of Rejection

Previous research has shown that people suffering from high self-criticism are often fearful they may be rejected by others (Mongrain, Lubbers & Struthers, 2004). They are highly attuned to any potential rejection. They experience any rejection as very painful and distressing. Sadly, research further indicates they may be more likely than others to experience rejection, in part due to their interpersonal style (Mongrain, Vettese, Shuster & Kendal, 1998; Vettese & Mongrain, 2000). The present research extends the findings on the fear of rejection to the therapy context. Participants expressed fears of being rejected by their therapists. In my research, fear of rejection, as well as shame about one's problems led almost invariably in one direction – towards keeping 'secrets' from the therapist. Clients shared in the research interviews, that there were substantial issues they believed they needed to deal with that they had not made known to their therapists.

Six of the eight participants in this research had a very significant issue, which s/he believed needed to be addressed in order for therapy to be fully effective, and which s/he *had not revealed* to her/his therapist. This phenomenon of failing to apprise the therapist of the (most) difficult issues a client is facing has been mentioned by others (Blatt & Shahar, 2004a; Mallinckrodt, Gantt & Coble, 1995; Meyers & Pilkonis, 2002). For a couple of participants, they had chosen not to make a past therapist aware of the issue, but had shared it with their (then current) therapist. The comments these latter participants shared during their research interviews suggested that being honest and upfront with their current therapists was experienced as helpful and contributing to them benefiting more from therapy.

From what was shared by participants, it seemed there were multiple interacting reasons for keeping significant problems or experiences from the therapist. Shame and a fear of rejection played a part. They were ashamed about the issue or feared the therapist might reject them if s/he knew about it. A lack of trust in the therapist and/or his abilities to cope with the knowledge and to help the client with that problem sometimes influenced decisions whether or not to disclose. Fear of 'failing' at therapy also influenced one participant's decision to conceal certain things. Keeping important problems secret also appeared to be one of the coping strategies used by participants. That is, it was easier to maintain control of their emotions and to manage the distress that resulted from therapy when they did not work on addressing those painful 'hidden' issues.

This pattern of using avoidant coping strategies is common both to individuals struggling with depression (Avants, Warburtin & Margolin, 2000; Dyson & Renk, 2006; Öngen, 2006; Rudnicki, Graham, Habboushe, & Ross, 2001; Yapko, 1997, 2006) and to individuals who are very self-critical (Dunkley & Blankstein, 2000; Dunkley, Zuroff & Blankstein, 2003; Dunkley, Zuroff & Blankstein, 2006; Saragovi, Aubé, Koestner & Zuroff, 2002; Stöber & Joormann, 2001; Zuroff, Moskowitz & Côté, 1999). The desire/need for approval can be seen as the corollary of the fear of rejection that all-too-frequently accompanies the trait of SC. Several participants expressed the

desire to meet their therapists' approval. One participant admitted feeling some reluctance to be honest about how she was doing at one point for fear her therapist would be disappointed in her. Thus, for a self-critical client, the need for approval and the desire to appear "successful" could contribute to the temptation to hide important (or even minor) problems from his therapist. Similarly, shame and disappointment with self regarding the decision not to apprise a therapist about a specific issue could hamper therapeutic progress, as well as contribute to diminished ability to acknowledge and celebrate positive changes and therapeutic success.

It seems likely that part of the reason self-critical clients in this research had not gotten all they had hoped to from therapy was because they were not working on resolving some of their most painful and significant past issues. In fact, one might surmise that a client would have to expend considerable time and energy in therapy on vigilantly avoiding that issue or discussions of other issues that could lead to that hidden one. These findings imply that another significant possible explanation for why very self-critical clients do not benefit from therapy as much as others is due to them not sharing with their therapist and addressing one or more deeply troubling problem(s). Henkelman (2004) completed research about hindering experiences in therapy. By contrast, one of her research participants identified being unable to 'hide' from his friend or himself as an important aspect of a relationship he found therapeutic. We are only just beginning to identify and understand this phenomenon. Further research is needed to determine how common 'hidden,' unaddressed issues are among self-critical clients, when it is beneficial to keep information from one's therapist, and what impact undisclosed issues have on therapeutic outcomes.

Central Importance of the Therapeutic Relationship

The therapeutic relationship was affected by participants' self-criticism. They showed signs of lacking trust in their therapists. Participants' experience of therapy and their ability to benefit was also impacted by the quality of the therapeutic relationship. Negative experiences in therapy kept them from benefiting as much as they might have. The value placed on the

therapy was also influenced at times by the relative rank of the therapist and participant. Each of these will be discussed in turn.

This research suggests that very self-critical clients may struggle with developing a trusting relationship with their therapists. I suspect that this lack of trust is difficult to detect most times. For instance, the participants did not express a lack of trust in their therapists. Nonetheless, there was crucial information about themselves and their problems that they were not sharing with their therapists. That was very likely partly related to their level of trust. It may be that very self-critical individuals need to spend more time developing and strengthening the therapeutic bond than do other clients before they feel safe to be completely open and honest about all the problems they are having. Lack of trust and the practice of concealing issues from therapists might help clarify the findings of Blatt, Zuroff and their colleagues (see Blatt, 1999; Blatt & Zuroff, 2005; Blatt, Zuroff, Quinlan & Pilkonis, 1996; Shahar, Blatt, Zuroff, Sotsky & Krupnick, 2004; Shahar, Blatt, Zuroff & Pilkonis, 2003; Zuroff, Blatt, Sotsky, et al, 2000; Zuroff, Blatt, Sanislow, et al, 1999), who found the in the NIMH-TDCRP that the working alliance of very self-critical patients seemed to 'plateau' midway through therapy, while it continued to grow stronger for less self-critical patients.

Recently, increasing attention has been paid to the kinds of experiences and counsellor behaviours that hinder therapeutic progress. Paulson, Everall and Stuart (2001) identified nine aspects of counselling that were found to either hinder therapy or to be unhelpful, including "concerns about vulnerability, lack of commitment and motivation, uncertain expectations, lack of connection, barriers to feeling understood, structure of counselling, negative counsellor behaviours, insufficient counsellor directiveness, and lack of responsiveness" (p. 56). Most of the participants in this research mentioned negative experiences they had had in therapy that correlated with the nine identified by Paulson et al.

Participants in this research related many incidents that parallel the kinds of experiences that have been previously identified as events that hinder therapy (Henkelman, 2004; Henkelman & Paulson, 2006; Paulson,

Everall & Stuart, 2001). For instance, Debora told of a therapist who had a 'pet theory' of the reasons for her problems that paralleled his own life history. Despite her insistence that her reasons and situation were different, he apparently would not let go of this theory. This demonstrated not only a lack of understanding of the client, but likely also a lack of insight into his own processes and issues. Another hindering experience participants had was a lack of responsiveness from previous therapists. Participants shared how painful it was to be with a therapist who appeared unmoved and unaffected by their expressions of emotions. Literature on the psychology of emotions reveals that emotional expression is a primary way humans communicate with and motivate others (Elliott, Watson, Goldman & Greenberg, 2004; Mahoney, 2003). In light of this, it is not surprising that participants found their therapists' unresponsiveness distressing and hindering to therapeutic progress.

The participants had a number of stories to tell about unhelpful and even harmful experiences in therapy. On occasion, therapists acted in ways that were perceived as judgmental, which as often as not led to the end of that particular therapeutic relationship. A seemingly judgmental or withholding therapist would have a negative impact on any client. Lack of connection between client and therapist has been found to greatly hinder the therapy process (Paulson, Everall & Stuart, 2001). Henkelman (2004) interviewed psychotherapy clients to find out about their hindering experiences in therapy. She found that therapy was hindered for a participant who did not feel "personally valued" by her therapist. Henkelman commented, "A personal connection with the counsellor is necessary" (p. 25). The effects are probably much worse, however, for a self-critical individual who is already struggling with fear of rejection and disapproval, and feelings of guilt, unworthiness and inferiority. Similar to what was found here, Henkelman (2004) found that feeling a lack of empathy from and connection to one's therapist hindered clients' progress. The participants tended to change therapists when they felt judged or when they perceived a lack of emotional connection with their therapist.

Refusing to give direct, open and honest feedback and advice, especially when specifically requested by the client, was hurtful to participants and appeared to weaken the therapeutic alliance. Paulson, Everall and Stuart (2001) found a similar phenomenon in their research into hindering events. Specifically, when counsellors gave insufficient direction and when they lacked responsiveness to their clients, they hindered the clients' therapeutic processes and progress.

A focus on achievement and high personal standards are hallmarks of SC. Since very self-critical individuals are often plagued by feelings of unworthiness, it is not surprising that concerns related to rank and power were evident in this study. Several participants were quite aware of their own rank or status relative to their therapist's. The fact that there was perceived inequality, with the therapist below the client, contributed to those participants experiencing therapy as less effective. In a similar vein, it was important to one participant that his therapist not be in a position of power over him; that she not be an authority figure. It would seem that a therapist with too much or too little perceived power would be less effective with a self-critical client than a therapist who was able to create an egalitarian, collaborative relationship with her client (Henkelman & Paulson, 2006; Hubble, Duncan & Miller, 1999). Research into the interpersonal effects of SC suggests that people who are highly self-critical tend to want to maintain their sense of status and self-worth, even at the expense of relationships with others (Santor & Zuroff, 1997). In the therapy context, that may mean that preserving a self-critical client's status requires that s/he not accept help that comes from "a lesser being" (Arlene's descriptor).

Need For Time

Self-criticism may have had a particular effect on the amount of therapy participants in this research had and needed. An extensive history of past therapy was not uncommon for participants. There were indications that limiting the amount of therapy participants could engage in had a deleterious effect. The present findings confirm and strengthen arguments for more long-term counselling for certain kinds of clients.

A crucial finding of the present research was the fact that some participants had been in therapy multiple times. One reason for the extensive history of therapy was that participants did not yet feel better, did not feel as though they had changed, or did not feel they had achieved what they wanted/needed to in therapy. For some, finding a therapist with whom they could develop an adequate bond or connection was challenging. Therapy would be initiated then abandoned by the participant because s/he felt for some reason s/he would not be able to work with the therapist. Participants described meeting with therapists who seemed to be judgmental, apparently disinterested (e.g., hidden behind a stack of papers on the desk), hope-destroying (e.g., citing statistics to prove a client was unlikely to be able to overcome a particular problem), or who did not seem to show an adequate comprehension of the client's problem(s). Progress was then delayed while the participant searched for and began working with a new therapist.

Limits on the number of sessions a participant was allowed seemed to have a negative impact. Henkelman (2004) also found that the imposed ending of therapy interfered with progress for one of her participants. Time pressures and limitations on the amount of therapy participants could receive influenced their decisions regarding whether or not to tell their therapists about some of the issues they faced. In some ways, the decision to keep a significant issue from a therapist could be understood as appropriate and adaptive. Clinicians and clients alike are often aware of the detrimental effects of opening up an issue in therapy when there is insufficient time to fully address it. It is often better to leave the problem alone in such cases. The information from some of the participants provided evidence that time limits on therapy inhibited them from attempting to address some of their deep and painful problems with their therapist.

These results buttress the small but growing body of research that indicates that some people are unable to obtain lasting benefits from therapy when it is very brief (e.g., less than 12 sessions; see Blatt, Sanislow, Zuroff & Pilkonis, 1996; see also Blatt, 2004; Blatt & Shahar, 2004a; Blatt &

Zuroff, 2005; Consumer Reports, 2004; Layne, Porcerelli & Shahar, 2006; Porcerelli, Shahar, Blatt, Ford, Mezza & Greenlee, 2006; Shahar & Blatt, 2005; Westen & Morrison, 2001). Consensus is developing around the idea that while many people with less severe problems can benefit from brief interventions, when the issues are severe and longstanding, therapy too must be longer term.

The evidence available (Blatt, 1974; Blatt & Blass, 1990; Blatt & Homann, 1992; Blatt, Cornell & Eshkol, 1993; Blatt & Zuroff, 1992; Levy, Blatt & Shaver, 1998; Meyers & Pilkonis, 2002; Zuroff & Fitzpatrick, 1995; Zuroff & Mongrain, 1987; Zuroff, Mongrain & Santor, 2004) indicates that SC develops in childhood and likely even in infancy. Those self-critical ways of thinking, acting and feeling are entrenched and therefore require long-term intervention to change or alleviate them. The present research supports such a conclusion.

Implications for Counselling Self-Critical Clients

I would like to make several recommendations for working with self-critical clients based on this research. The recommendations relate to three areas; the therapeutic relationship and working alliance, the importance of identifying SC as a therapeutic issue, and the impact of time limits on therapy with self-critical clients.

The Therapeutic Relationship and Working Alliance

As is the case in all therapy, the working alliance and therapeutic relationship are crucial in determining outcome, and individuals with high SC pose a number of special challenges in that regard. The importance of the relationship has been well established in the research on the therapeutic alliance (Beutler & Harwood, 2002; Chatoor & Krupnick; 2001; Hersoug, Monsen, Havik & Høglend, 2002; Horvath & Symonds, 1991; Howgego, Yellowlees, Owen, Meldrum & Dark, 2003; Joyce, Ogrodniczuk, Piper & McCallum, 2003; Spinelli, 2002) as well as in the area of SC (Blatt, Sanislow, Zuroff & Pilkonis, 1996; Blatt & Zuroff, 2005; Blatt, Zuroff, Quinlan & Pilkonis, 1996; Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004; Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow & Simmens, 2000). When considering

recommendations related to the working alliance, I will discuss matters related to attachment, the internalizing of a "good object," the necessity of detecting and repairing relationship ruptures, as well as the need to improve social support networks.

Attachment issues. Research strongly indicates that people who are highly self-critical tend to have anxious-avoidant attachment styles (Blatt & Homann, 1992; Koestner, Zuroff & Powers, 1991; Zuroff & Fitzpatrick, 1995). Eames and Roth (2000) found that therapy clients whose attachment systems were characterized by anxiety and avoidance of intimacy had poorer working alliances than people with more secure attachment systems. Also, research has shown that individuals with a secure attachment style obtain greater benefits from therapy than those with insecure attachment styles (Alford, Lyddon & Schreiber, 2006; Eames & Roth, 2000).

Consequently, therapy needs to provide a 'corrective emotional experience' (Eames & Roth, 2000) for clients; a relationship where they can experience feelings of safety, security and acceptance. A number of researchers and clinicians (see for instance Alford, Lyddon & Schreiber, 2006; Eames & Roth, 2000; Mallinckrodt, Gantt & Coble, 1995; Safran, 1993) argue that therapy in general needs to provide this 'corrective' attachment experience, and the present research supports that. It is hypothesized that developing a secure bond with their therapists will enable clients, including very self-critical ones, to reduce emotional distress and negative affect, and experience more positive affect, as well as develop more supportive interpersonal relationships outside of therapy. A positive therapeutic relationship that develops early in treatment has been shown to be strongly associated with more positive outcomes both during therapy and later on (Zuroff & Blatt, 2006).

There are many good reasons for wanting to help clients develop secure attachment styles. The benefits seem enormous. Individuals who have developed a secure attachment style tend to have more positive, optimistic relationships with others. They experience social interaction as more enjoyable and encouraging than people with insecure attachment

styles. They are more resilient in the face of adversity and tend to have better problem-solving skills (Blatt & Homann, 1992; Meyers & Pilkonis, 2002; Mikulincer & Shaver, 2005a).

Another reason developing a strong therapeutic bond is important is because self-critical clients are expecting criticism, judgment and rejection. It is then doubly important that therapists embody those classic Rogerian qualities of acceptance, respect and unconditional positive regard. By embodying these qualities, therapists provide an 'object' that clients can internalize, who is accepting, nurturing and supportive and who can counteract previous experiences with caregivers (or significant others) who were rejecting, neglectful, harshly critical or emotionally unavailable. Indeed, these are precisely the qualities participants in this research identified as helpful and supportive within therapy. It was crucial for them to have a therapist they felt accepted by and who did not judge them (see also Layne, Porcerelli & Shahar, 2006). Hawley, Moon-Ho, Zuroff and Blatt (2007) found that a strong working alliance led to improvements in personality vulnerability (e.g., less SC), which in turn reduced patients' symptoms of depression. They asserted, "...one of the primary goals for therapists who wish to work effectively with perfectionistic patients involves establishing a strong, collaborative therapeutic alliance early in therapy..." (p. 939).

Repairing Alliance Ruptures. Closely aligned with the need for establishing a strong therapeutic bond is the need for the therapist to be sensitive to ruptures in the therapeutic alliance, whenever they occur, to raise these with the client and to address them directly. The therapist will need to warn the client to expect some occasional albeit minor ups and downs in their relationship, and to enlist the client's help in letting the therapist know when they occur. Safran and Muran (2000) view alliance ruptures as co-constructed between counsellor and client. Ruptures provide the two with great opportunities for achieving deeper understanding of themselves, each other and their relationship, and for making therapeutic progress. The therapist thus has a responsibility to notice ruptures and create

a therapeutic conversation about them and their effect on the relationship. Conversations about ruptures enable therapist and client to enrich their relationship. When the therapist is sensitive to ruptures and actively engages the client in repairing the relationship, he is sending the client the message that her needs and feelings are worth noting and responding to, and that the relationship is important enough to the therapist to bother salvaging. The client is also provided with a template for approaching other relationships outside of therapy.

Changing Social Supports. Repairing ruptures in the therapeutic relationship provides an important learning experience for self-critical clients. Beyond changing how they see and treat themselves, self-critical people need assistance to develop stronger, more positive social support networks (Shahar, Blatt, Zuroff, Krupnick & Stosky, 2004). As mentioned, they tend to experience a great deal of rejection and criticism from others (Mongrain, Lubbers & Struthers, 2004). In order to change their self-perceptions, they also need to change the environment they inhabit.

Identification of Self-Criticism as a Therapeutic Issue

Because SC can undermine therapy, it is important that it is identified and addressed. Methods for identifying SC will be discussed below. I will also further delineate the patterns of thinking, feeling and acting that accompany high SC, that clinicians and clients alike need to be aware of and to address in therapy.

Identifying Self-Criticism. What this study revealed is that often, SC has not been identified as a therapeutic issue and thus is not being addressed. Part of the feedback I received as a researcher was that most participants found it very helpful and thought-provoking to have their SC identified, labeled, and to discuss the various ways it might be affecting them, their therapy, their lives and relationships. Because SC has such detrimental effects on people both within and outside of therapy, it needs to be acknowledged and directly addressed (Layne, Porcerelli & Shahar, 2006; Powers, Zuroff & Topciu, 2004).

Once SC had been identified as a relevant therapeutic issue, specific areas of potential problems should be considered. These will likely differ from the areas of therapeutic focus with a client who is not highly self-critical. The need to tailor treatment to match client characteristics is increasingly being recognized as important. Research on depression (e.g., Heim, Plotsky & Nemeroff, 2004) provides support for the theoretical contention that there are different subtypes of depression that will respond differentially depending on the treatment given. Self-criticism needs to be identified as highly correlated with both interpersonal problems and depression. Treatment then needs to be tailored to address the unique therapeutic needs arising for very self-critical clients. Powers, Zuroff and Topciu (2004) noted that treatment strategies targeted specifically to deal with issues surfacing as a result of SC are only just beginning to be developed.

Given that depression is one of the most common reasons people have for entering therapy (Brundtland, 2001; Consumer Reports, 2004; Manderscheid, 2006; Räty, Ikonen & Honkalampi, 2006; Seligman, Rashid & Parks, 2006; Solomon, 2006; Statistics Canada, 2003; Watts & Markham, 2005; Wu & Anthony, 2000) and that self-criticism is highly correlated with depression, it would make sense that this personality feature would be regularly identified and addressed in therapy. This does not seem to be happening in any structured kind of way.

The DEQ (Blatt, D'Afflitti & Quinlan, 1976), a measure proven to reliably identify SC, is primarily used for research purposes and is not often used within a non-research, private practice setting. Thompson and Zuroff (2004) have developed the Levels of Self-Criticism Scale. This scale distinguishes between comparative SC and internalized SC. However, the authors contend more research is needed on this instrument, and it may not currently be ready for use with clinical populations. Powers, Zuroff and Topciu (2004) developed the Self-criticism Scale, a seven item tool that may in the future prove useful for identifying self-critical individuals in practice (vs. research). Its brevity could make it attractive to practitioners. Clinicians need

to be made aware of the prevalence of SC as well as its effects on therapy, so they can consistently identify and remedy it.

The majority of the participants in the present research agreed they are very self-critical, but generally this had not been addressed within the context of therapy. Some of them said after their research interviews that they planned to bring it up with their therapist as something to work on in the future. Others mentioned it gave them a great deal to think about, and a new perspective on their problems and possible solutions. Blatt and Zuroff (2005) pointed out that the quality of the therapeutic relationship and the level of pretreatment perfectionism significantly impacted treatment for depression. Their research and mine both reflect the importance of identifying and directly addressing SC with therapy clients.

Matching Treatment to Client. Blatt (2004) and his fellow researchers are among those calling for matching therapies and interventions to clients. Dunkley, Zuroff and Blankstein (2003) found evidence to suggest that self-critical perfectionism has a strong cognitive component, while people with Dependent personality traits were more responsive to supportive-expressive psychotherapy. Blatt and Shahar (2004a) argued that psychoanalysis is the preferred treatment for clients with self-criticism because "Introjective (or self-critical) patients, by contrast, are more responsive to the interpretive aspects of the treatment process and the insights gained in treatment than to the relational aspects of the treatment process..." (p. 429). Much of their research on the NIMH-TDCRP indicated that self-critical patients benefited more from psychoanalysis than from supportive-expressive psychotherapy.

There are many different ways to tailor therapy so that what is provided matches the needs and personality of each individual client. In addition to choosing a particular therapeutic approach (e.g., psychoanalysis vs. psychotherapy), my research leads me to believe that a practitioner would do well to solicit feedback from her clients about what they feel works for them. One type of feedback that participants in this research appreciated being able to give to their therapists was when an intervention was not helpful or effective. Their comments provide strong

evidence to support practicing a flexible, eclectic, and integrated style of therapy. As solution-focused therapists (Berg, 1994; de Shazer, 1985) admonish their clients, if something does not work, do something else. It seems the same goes for therapists. The participants repeatedly said how much they valued when their therapist kept trying different approaches until they found what worked.

One promising new approach to working with individuals who are both highly self-critical and experience an unusually high amount of shame has been developed by Gilbert and Proctor (2006). They asserted that people who experience high shame and self-criticism often struggle with effectively engaging in self-soothing when they are in distress. Such individuals tend to have problems that are "...chronic, and who find self-warmth and self-acceptance difficult and/or frightening" (p. 353). Gilbert and Proctor developed a therapeutic intervention based on both Buddhist philosophy and mindfulness training. Through the group, participants in their study learned how to engage in self-compassion and to develop self-warmth. Participants were able to reduce levels of anxiety and depression as well as self-criticism and shame. They also increased their abilities to effectively self-soothe and self-reassure.

While I believe it is important for a therapist to know when her/his client is self-critical, I would not want this to become reductionist or simplistic. Therapists have to see their clients as more than their self-critical tendencies. Mahoney (2003) wrote,

> Psychology and Psychotherapy have become heavily categorical. The profession seems to both breathe and breed classification. Classification is a useful tool, of course. It helps us organize and communicate our experience. But tools can sometimes become tyrants. Abraham Maslow called it the law of the hammer: We start finding ourselves pounding everything. When we fall into the habit of experiencing and describing our clients as nothing but their diagnoses, we have lost control of a very powerful tool. More important, we have

> lost a precious sense of our clients' uniqueness as flesh-and-blood, trial-and-error persons (p. Xi).

Common Self-Critical Characteristics to be Addressed. It is important for both therapists and clients to be educated regarding the common patterns and challenges of SC. The therapist would want to monitor for evidence that these types of reactions or feelings are occurring in therapy, and to work through them with the client. Concerns over rejection, judgment and/or evaluation might be primary among the feelings to watch for. A client might be asked to check herself for feelings of being judged or rejected by the therapist, and to bring these to the therapist's awareness.

Similarly, it would be beneficial for therapist and client to examine the client's experiences of and comfort with happiness and success. Questions to consider are: Is happiness uncomfortable or unnerving? Is it hard for the client to recognize improvements or achievements? How does he feel when he receives affirming and encouraging feedback from his therapist? One clue indicating the need to address self-criticism might be if a person frequently feels the positive feedback she receives from others is incongruent with her internal experiences of herself. Self-critical clients need support and likely instruction on how to cope with affirmations they receive and with therapeutic improvement.

One of the most noteworthy findings of this research has been uncovering the tendency for participants to withhold vital information about themselves and the issues they believe they need to deal with from their therapists. Practitioners working with very self-critical clients would do well to directly ask, once the therapeutic relationship has been established, if there is anything the client believes s/he needs to concentrate on or resolve in therapy but has been reluctant to disclose to the therapist. In fact, it might be very therapeutic for the client to safely reveal the issue, receive acceptance and support from the therapist, and make a deliberate choice about when to work on this previously 'hidden' problem. Having one's therapist's support to defer working on a particular difficulty could reduce feelings of shame and failure in the client that might otherwise arise from

having knowingly hidden the problem from the therapist all the while believing it needed to be resolved in order to get better.

Another area that needs to be dealt with is that of self-definition. Somehow, clients need to be assisted to change their self-views to allow for recognition of achievements, accomplishments, and most importantly, positive relationship experiences. Working in therapy and directing that outward, clients need support to recognize and 'own' those occurrences when they are not rejected, judged or criticized and were expecting to be; when they are accepted and appreciated; when others – therapist included – prove reliable and trustworthy. Clients may need to make a conscious effort to notice and be affected and changed by positive experiences. In other words, the tendency to minimize and discount themselves needs to be altered.

Furthermore, the therapist would want to work with a very self-critical client to prepare him/her for positive changes. This would include bringing to the client's attention his/her (possible) tendencies to ignore, minimize and discount strengths, positive changes and progress, as well as to address the discomfort an individual could experience at being 'confronted' with evidence of the growth and change that is occurring. Clients need to be prepared for the uneasiness and adjustment that comes from these types of changes. They need to be coached to resist the urge to "fight off" positive feedback from their therapists or from others. They may similarly need support to experience the benefits of positive affective states, as well as the mood-enhancing effects of social interaction.

Likewise, self-critical clients may need assistance to help them deal with how positive changes may affect their social support network. There are two overlapping areas that need to be considered. First, clients need to be supported to create more positive social relationships. Second, they need to be supported to cope with and actually feel comfortable with these more positive social relationships.

The Risks of Limiting Therapy

Another implication this research has for current practice is that the results strongly suggest that limiting the number of therapy sessions available to highly self-critical clients does them a grave disservice. Nearly all of the participants had previous experiences in counselling. Most had been to several other counsellors, not just one. Some of these previous experiences were very beneficial, while others were harmful or at the least *not helpful*. What this suggests is that some highly self-critical clients may require a substantial amount of therapy – often over a period of years – in order to come to a satisfactory resolution of their issues and to feel they have benefited as much as they wanted or hoped to from therapy.

Luyten, Blatt, Van Houdenhove and Corveleyn (2006) expressed serious concerns over the use of brief treatments for depression, given their limited efficacy. They and others (Blatt, Sanislow, Zuroff & Pilkonis, 1996; Blatt & Shahar, 2004a; Blatt & Zuroff, 2005; Consumer Reports, 2004; Layne, Porcerelli & Shahar, 2006; Porcerelli, Shahar, Blatt, Ford, Mezza & Greenlee, 2006; Shahar & Blatt, 2005; Westen & Morrison, 2001) contend that treatment needs to be long-term and intensive as well as specifically designed to address issues of self-criticism. The benefits of short-term therapy appear to be short-lived. Short-term improvements could serve to reinforce a self-critical individual's beliefs that good things do not last.

Limiting the number of sessions at times served mostly to interrupt the flow and progress of therapy, according to the participants in this research. The client was left to find a new therapist and in essence, start over, a daunting task – especially for a very self-critical person who tends to anticipate judgment and rejection from others. The participants recounted difficulties they had had in the past finding a therapist who was effective and whom they felt they could work with. It is not only highly self-critical clients that may need to put some effort into finding a therapist whose style 'fits' for them. However, the literature suggests that highly self-critical individuals often have trouble in interpersonal relationships and so this often contributes to problems in developing a good working alliance with their

therapists (Blatt, 1999; Blatt, Zuroff, Quinlan & Pilkonis, 1996; Mongrain, Lubbers & Struthers, 2004; Mongrain, Vettese, Shuster & Kendal, 1998; Santor, Pringle & Israeli, 2000; Santor & Zuroff, 1997, 1998; Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004; Vettese & Mongrain, 2000; Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow & Simmens, 2000; Zuroff & Duncan, 1999; Zuroff, Moskowitz & Côté, 1999).

While there were not many limits other than sheer time[22] placed on participants in my research, for most of them, the amount of therapy they received was not enough. This is very important information, because some of them received as many as 20 or more sessions in the course of an academic year. Nathan, for example, continued in therapy for a second year, and indicated plans to continue the following year as well. Significantly, he reported making some initial gains and 'laying a foundation' in his first year of counselling. He advised me he had made great progress the second year, which gave him hope that even further progress could be made if he continued for a third year. What all this suggests is that some highly self-critical individuals could quite likely be able to make as much progress in therapy as other individuals *if they had the opportunity to receive counselling for much longer periods than are currently available in most places.*

It may yet be shown that self-critical clients are not the only ones to require long-term therapy. Research on clients who were not specifically identified as self-critical (e.g., Consumer Reports, 2004) also led to calls for access to longer-term therapy for more clients. My results support the provision of long-term therapy to people who are struggling with SC and the effects it has on their lives. My follow-up interview with Nathan provided a remarkable example of how beneficial long-term therapy can be. Despite having to change therapists, Nathan had made considerable progress over the two school years that he was involved in counselling. Notably, he had identified that critical inner voice, named it his "inner bully," and was

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[22] In the Education Clinic, student therapists work with clients no longer than from September to April.

learning how to overcome it. His whole demeanor and presentation had changed between our research and follow-up meetings. Instead of being tentative, cringing and expecting a horrible experience (as he did during our first interview), Nathan scheduled our appointment when he felt ready to talk about his experiences of participation in my research and his experiences in therapy, demonstrating self-care and self-respect. He was open, honest and proud of what he had accomplished and how far he had come in therapy. He spoke highly of his experience of therapy, and shared freely about the challenges and victories he had had. Most significantly, Nathan was planning to continue in therapy for at least another school year.

Directions for Future Research

Future research with individuals who are highly self-critical would ideally encompass several different aspects. It would be helpful to engage in a process similar to the one used in this research, but to specifically select highly self-critical clients currently in therapy who appear to have reached that "plateau" where they are no longer making progress. The researcher might explore with them, using interviews and IPR, the possible reasons why they may no longer be making gains in therapy. Also, one wonders how many of the very self-critical clients who are in therapy are not fully "present" and participating because a part of their conscious mind is busy evaluating what they are saying or about to say, their therapists' reactions to what they do or do not say, the interventions their therapists have chosen to use, or how effective their therapist is being, and so on. Further research might reveal how much internalized self-critical processes are interfering with participation in therapy.

Some of the participants in the present research had had a lot of previous therapy. It would be worthwhile to know more about the sheer amount of time clients who are very self-critical spend in therapy during their lives. More information needs to be obtained regarding how much therapy very self-critical clients have had, how many therapists, what kind of benefits they gained from therapy, what they experienced as "good therapy," what was "unhelpful," and what was "harmful." It would be informative to know if

there was an approximate amount of therapy needed to achieve long-lasting benefits. Future research could also help unravel the effects of having several different therapist over a period of years versus having one long-term therapist. Knowing that information could help determine if therapy and therapists are like trying to quit smoking: do the chances of success increase with the amount of therapy one has? Are better therapeutic outcomes more often associated with fewer therapists? Or more?

I think the finding that many of the participants in this research had some important issue they had not yet revealed to and/or addressed with their therapist, but believed they needed to is something that deserves further study. We do not yet know the impact of disclosing instead of continuing to hide issues in therapy, nor even how prevalent this phenomenon is. The conditions that lead to disclosing or concealing are not yet known.

There is also a need to research further into the area of trust with self-critical clients. Are they not sharing 'hidden issues' due to a lack of trust? If so, how could that be remedied? There also seems to be a dearth of information regarding therapy drop-out rates for very self-critical clients. A better understanding of when 'drop-outs' are likely to occur and probable causes would aid in addressing these problems. The reasons very self-critical clients terminate therapy prematurely or change therapists might differ from the reasons other clients quit or change therapists.

Additionally, I think it would be useful to conduct some interviews of therapy clients including people with both high and low self-critical tendencies to compare their responses. This might illuminate the reasons for lack of progress among some very self-critical clients. Relationships are dynamic and influenced by all parties involved. Therefore, it might be useful to conduct research to explore how therapists are affected and changed by their very self-critical clients. In a similar vein, it could be beneficial to uncover self-critical tendencies in therapists and attempt to unravel their effects on therapeutic outcomes. A therapist, for instance, who has extremely high standards might easily become discouraged with himself, his

therapy and his clients. He might fail to appreciate improvements and accomplishments in his clients and so fail to inspire hope.

Lastly, in the future it would be beneficial to undertake research that would help practitioners understand the social milieus of very self-critical clients. We are beginning to gain a picture of what their environments might be like. There is an awareness that self-critical individuals often inhabit very negative stressful worlds. More work is needed to determine how to assist clients to create more positive relationships and social networks outside of therapy. Helping self-critical clients enter into and feel comfortable in more positive, nurturing environments might be one of the most significant ways to help them overcome their self-critical style completely.

Limitations of the Present Work

The reader is reminded that these findings may be applicable only to therapy clients who are very self-critical, as indicated by high scores on the DEQ. It may also be applicable only to those clients who are very self-critical and who are working with student clinicians or novice therapists, as was the case in this study. However, much of what was found to be helpful or hindering in terms of therapist actions was very similar to the results of research conducted with more seasoned practitioners. Further research confirming and extending these findings would also expand their generalizability. Similarly, while there is evidence to support the theory that self-criticism transcends cultures, this research was conducted with primarily Caucasian participants. Therefore, the generalizability to persons of other racial and cultural heritages is unknown.

There were also limitations created by the methods employed to gather the data in this research. I suspect a great deal more could have been learned by going back and forth between participants after the initial interviews, to ask them about things that came up in other interviews, but not specifically in their own. For instance, the last participant I interviewed talked about his anger and the problems he had with it. Anger was not really talked about by other participants, but it might have been had I known to bring it up. Perhaps other participants had difficulties with anger,

that they were also addressing or wanting to address in therapy. Anger may have caused interpersonal problems for them or could have affected their relationship with their therapist. My research was not structured in such a way as to facilitate that. I did not ask participants to be available for those types of inquiries. To do that would have required the participants to commit even more time than they were already giving for the interviews. However, it might have provided valuable information about SC.

While participants were assured they were welcome to make any comments or ask any questions about their interview and about the taped session we watched, my interview questions were geared toward uncovering aspects of SC. This may have influenced what participants chose to talk about, or focus on. Perhaps having more latitude to discuss whatever they felt enhanced or impeded their progress in therapy would have led to quite different findings.

Contra-indications for this type of research

One concern that has nagged me since beginning the analysis of the interviews has been the idea that participating in this research might have increased the amount of SC clients experience in therapy. By having clients view tapes of themselves and engage in discussion, some self-critical tendencies were evoked during the research interviews. One possible negative outcome could have been that clients were more self-aware in a negative sense or more self-critical during therapy after they participated in the research interviews. I have no evidence that this happened for any participant, but future researchers need to be vigilant to ensure that they are not creating subtle negative long-term experiences for research participants who are very self-critical.

CONCLUSION

Through this research a great deal has been learned about the internal experiences of self-critical clients in therapy. Some light has been shed on how SC interferes with therapeutic progress. Fear of judgment or rejection may be leading some clients to 'hide' significant issues they are facing from their therapists. The tendency to minimize and discount

therapeutic progress and positive experiences could be undermining the process of therapy with very self-critical individuals. Nonetheless, self-critical participants in this research deeply appreciated positive feedback from their therapists. Moments when they felt safe and understood were highly prized. They appreciated a persistent therapist who would keep trying different techniques to find the one(s) that worked best for them. Lastly, they showed themselves to be a resilient and determined group – not giving up on themselves or therapy, but persisting until they really and truly felt better.

EPILOGUE

The Experience of Being a Self-Critical Researcher

A friend recently asked me how things were coming along on my dissertation. I explained that I was nearly ready to defend my research into the experiences of self-critical clients in therapy. Knowing me well, he asked if I was ready to defend the dissertation on the self-critical grad student. There is some kind of bittersweet irony to a self-critical researcher trying to complete a dissertation about very self-critical clients' experiences in therapy. I often found myself wondering if the same things that 'trip up' self-critical clients in therapy were tripping me up in my work. I can't count the number of times when my own inner critic has shut down my work on this dissertation. "You're doing it all wrong." "These are not the right themes." "What is Bill going to think of this? He'll think it's pure sh*te." "Your interviews are no good. You didn't ask the right questions. You didn't follow up the right leads. There really is nothing useful in your interviews." "This is pure crap. Sooner or later, your committee's going to figure it out." The litany goes on, about any and every aspect of the process, from the articles chosen for my literature review to my methodology to my findings.

That's not to say that there haven't been moments that were the exact opposite of these ones I've described above. There have been many of them. The sun breaks out from behind the proverbial clouds and I feel like, "Wow! This is really great stuff! I really know this stuff!" or "These interviews are fantastic!" or "These findings could be really important!" Those moments did occur. They were like treasures unearthed after clawing through a mountain of sand. They were the life-preserver, tossed out to me, keeping me from sinking below the surface of that ocean of despair that seemed so much my own making.

What part of my self-criticism has hampered me the most? That ferocious internal dialogue, that infamous inner critic, whose voice sometimes whispers so low as to be inaudible. I didn't so much hear the criticism as feel the effects. I've become more sensitive to the effects as a result. I can tell when it is happening, even if I can't hear the voice. I notice

what happens. I can't seem to think straight. It feels like my brain is short-circuiting. I can't figure out what to do or how to do it. When that happened, I knew I would have to stop and chase down the demons in my head. I had to almost 'confess' to the criticisms that have been floating around in my head, "put the lie to them," as Dr. David Burns would say, and then carry on. They had to be brought out and illuminated. It seemed that they could not withstand the clear light of day. What in my mind was rock-solid, built of brick turned into feathery wisps of smoke and fog that vanished before my eyes.

This is why I think an important aspect of successfully addressing SC involves consistently identifying its presence and uncovering the processes with the client. I am a case study of one. Sort of. But one participant, Nathan, agreed with me. When his inner 'bully' started giving him a rough time, he would talk about it in session and then it could be dealt with and/or dismissed.

One way I overcame discouragement and self-critical moments was by thinking of running a marathon as a metaphor for my dissertation process. They say there's a simple way to run a marathon. Put one foot in front of the other. Repeat as necessary. Well-known runners and writers such as Jeff Galloway (1996) warn that finishing a marathon is as much a mental game as a physical one. Anyone who has run a marathon will tell you about 'hitting the wall.' Almost inevitably, a marathon runner, especially a first-time marathoner, will reach a point in the race where she believes she cannot go on, and just wants to give up. What the experts say is that if you've trained and prepared properly, and if you are not seriously injured, dehydrated or lacking food energy, you have the physical capacity to finish the race. It's your mind trying to trick you into giving up and thinking you can't do it. It's important to have prepared yourself mentally to deal with this phenomenon; to have the strategies in place to overcome the mental barriers. Most testimonials of first time marathoners contain a piece about how they did not think they could make it, but by persevering and sheer force of will, they did.

Throughout the completion of my Ph. D., training and running a marathon (well, only a half so far...) has been a metaphor for the process of becoming a 'doctor.' There have been short runs and long runs, hills and speed training, solitary runs and the company of other runners. It's been useful for me to think of my Ph.D., particularly my dissertation, this way. It has helped me stay focused on the end-goal, and to recognize all the mini-goals and milestones to reach along the way. Just like I sometimes have to simply keep plodding along with my running, even though I don't feel like it, I've had to keep slogging with my dissertation. I've had to keep putting one foot in front of the other.

In the Spring of 2006, I 'hit the wall.' I felt things I never imagined I would feel: like giving up and walking away, like quitting – even though I was so close to the finish line. It shocked me to find myself feeling like that. When I started the program, I always vowed I would not drop out of the race 'in the last mile,' with the end in sight. But I felt I just couldn't do it any more. The self-critical part of me dismissed all the progress I had made, ignored how having to do new interviews slowed the whole process, lead to me berating myself for not being able to get finished faster.

I started talking to others about how I was feeling, which helped immensely – because other people reminded me of how near the finish line I was. A friend asked me more than once what percentage of my dissertation I had completed and what percentage was left. My running metaphor came back to me then in a powerful way. In 2004, just weeks after my dad died, I ran my second half-marathon. It was a brutal run. By about 14 or 15 Km, I was starting to hurt. By 17 Km, all I wanted to do was give up. I didn't care. The only thing keeping me going was knowing that in order to get to back to my car, I had to go to the finish line. I could walk there or I could run. If I ran, I'd get there sooner. So I ran. I finished the race. In fact, my finishing time was a "PB" – runners' parlance for 'personal best.' When I thought about that race, I reminded myself of how close, relatively speaking, I was to the finish line of my Ph.D., when I was desperate to give up. I was so much closer to the end than the beginning. Yes, I had hit a wall, but it was a

mental wall. Not a real wall. The prize, the goal, the finish line remained in my grasp. I learned something else about SC and how important it is to help people lessen the effects of SC in their lives – ultimately, it was supportive interpersonal relationships that helped me make it to the end. But too many self-critical individuals are not presently able to benefit from a strong social support network.

I have learned a lot about SC and therapy clients who suffer from it, through this research process. I also learned a lot about myself. In both instances, I have come away feeling hopeful about what can happen in the future.

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Appendix 'A'

Information for Prospective Participants

Title: Self-Critical Experiences that Affect the Therapeutic Relationship

Principal Researcher: Gina Janzen
Department of Educational Psychology
1-135 Education North Building
Phone: (780) 492-3746[23]
Email: gjanzen@ualberta.ca

You are being invited to participate in a research study that is intended to explore the relationships people have with their therapists. Relationships – including relationships between clients and their therapists – are affected by many different things. A few factors that can influence how we relate to others are the internal standards we have for ourselves, the kinds of internal dialogues we have with ourselves as we interact with others, and the ways in which we evaluate ourselves self-critically – our thoughts, our abilities and our actions.

The purpose of this research is to explore and discuss the kinds of internal standards and internal dialogues people have and the kinds of self-evaluations people make, and how those things may be affecting the relationship between the client (that is, you) and the therapist. The hope is that having these discussions will help identify some thoughts, feelings, experiences or interactions that occur in therapy that may be keeping it from being as effective and helpful as it could be. It is also hoped that some of the thoughts, feelings, experiences or interactions that occur in therapy that make it more effective may also be identified through this process.

Your Rights as a Participant: You have the right

- To not participate in this research
- To withdraw at any time, and to decide at any point in the research process whether or not to continue to participate
- To opt out without penalty and any data collected from you will be withdrawn from the data base and not included in the study.
- To anonymity and confidentiality
- To safeguards for security of data (data are to be kept for a minimum of 5 years following completion of research)
- To disclosure of the presence of any apparent or actual conflict of interest on the part of the researcher(s).
- To a copy of report if you wish – it may be obtained by contacting me (see above information)

This research will be conducted by me; Gina Janzen, under the supervision of Dr. Bill Whelton, a professor of counselling psychology at the University of Alberta, Department of Educational Psychology. I (Gina) am

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[23] If I am not in, leave a message and I will return your call as soon as possible.

currently a graduate student in the Counselling Psychology program at the University of Alberta. I am in the process of completing my Ph.D. in Counselling. This research will be conducted in partial fulfillment of the requirements for that program. While the identity of participants will be confidential and anonymous, the research findings may be presented at conferences, used for teaching purposes and/or published in professional journals.

You will be asked to attend three to four (3-4) meetings with Gina Janzen, the researcher. At the first meeting, we will review the research and I will attempt to answer any questions you may have regarding me, the research, and/or the process(es) that you will be involved in. The second and possibly third meetings we will have will be to conduct an in-depth interview regarding some of your experiences during your therapy here at the Education Clinic. If possible, this will include reviewing a segment of videotape of one of the sessions you have had with your student therapist. These interviews will likely be one to three (1-3) hours long. The format will be relatively unstructured. The second (and possibly third) interview will be audio- and videotaped and then transcribed for later analysis. Your therapist at the Education Clinic will not have any information about your participation in this research other than the knowledge that you are participating. S/he will not be aware of anything you say regarding your therapy or relationship with your therapist. You are free to discuss any aspect of this research with your therapist, if you so choose.

Our final meeting will be some time later, after I have completed the transcription and begun the analysis of our interviews. At this meeting, you will have an opportunity to review the transcripts of our interview(s), and make any additions, corrections, or deletions you feel are necessary. You will also be given the opportunity to comment on my initial analyses at that time. The audio- and videotapes of our interviews will be kept in a locked filing cabinet in my home until the research is complete and they will be kept for a minimum of 5 years.

There is a possibility that participating in this research may negatively affect you or your relationship with your therapist. If discussion of your experiences raises any concerns for you that you wish to discuss further with a new counsellor, Gina will provide you with the names of individuals you can contact. Conversely, there is also the possibility that participating in this research may be beneficial and/or helpful for you. It might have a positive impact on your relationship with your therapist or enable you to benefit more from therapy.

This study has been reviewed and approved by the Research Ethics Board of the Faculties of Education and Extension at the University of Alberta. If you have questions regarding participant rights and ethical conduct of research, you may contact Dr. Derek Truscott at (780) 492-1161.

CONSENT TO PARTICIPATE IN RESEARCH

I, _____, have been invited by Gina Janzen to participate in her research project. I am aware that the purpose of this

research is to explore and discuss the kinds of internal standards, evaluations and internal dialogues I have and how those things may be affecting the relationship between me and my therapist. Through the use of an interview format, I will be asked to describe my thoughts, feelings, interactions and experiences in as much detail as possible. I may also be asked to watch a portion of a videotaped counselling session and comment on my experiences during that session. I understand that the present research is being completed by Gina Janzen, for her doctoral dissertation, as part of the requirements for the Doctor of Philosophy Program in Counselling. I also understand that Gina Janzen is working under the supervision of Dr. William (Bill) Whelton of the Department of Educational Psychology at the University of Alberta. I am also aware that the information obtained in the interview will be used by Gina Janzen for the purposes of this research and that the transcript of the interview conducted with me may be included as an appendix in her written report for the research. In addition to being analyzed for a Doctoral Dissertation, the results may be presented at conferences and/or published in professional journals, and possibly used for teaching purposes. In signing this form, I am giving my consent for the results to be used in this manner.

I have read the information about the research and am aware of my rights as a participant, as well as my right to decline participation. I agree to participate in the study and I am willing to share my experiences with Gina. I am aware we will meet on three to four (3-4) occasions, and that an interview of approximately one to three hours will be audio and/or videotape recorded and then transcribed for later analysis. I understand that my participation in this research is entirely voluntary and that I am free to withdraw at any time without penalty. If I choose to withdraw, any information about me and any data that I have provided will be destroyed. I am also aware that if discussion of my experiences raises any concerns for me that I wish to discuss further with a new counsellor, Gina will provide me with the names of individuals I can contact. I am aware that discussing my past experiences in counselling may impact my present experiences and/or the relationship I have with my current therapist.

I am aware that anything I say during my interviews with Gina Janzen will remain confidential. In particular, nothing I say will be communicated to my therapist at the Education Clinic. I am aware that my identity, and that of any person(s) that I mention, will be known only to Gina Janzen, and will not be revealed at any time. When transcribing the interview recordings, Gina will use a pseudonym for my name and for the name(s) of any other person(s) that I mention. These pseudonyms will also be used in preparing the written report for the thesis. Any details in the interview recording that might identify me or any other person(s) that I mention will also be changed during the transcription process. Gina Janzen will also be the only person with access to the tape recording(s) and the interview transcript, and these will be stored in a secure place. I also understand that the interview

recordings will be erased after the transcription process has been completed.

I am aware that participating in this research may have an unintended negative impact on my experience in psychotherapy, but that it could also be of benefit to me. I understand if I have any questions or concerns, I may speak to Gina Janzen at (780-492-3746) or her supervisor, Dr. Bill Whelton at the University of Alberta (780-492-7979). If I wish to contact a person from the University not directly involved in this research, with any questions or concerns I have, I may contact Dr. Derek Truscott at 492-1161.

Signature: _____

Dated at the city of Edmonton, in the province of Alberta, this _____ Day of _____, 20___.

"This study has been reviewed and approved by the Research Ethics Board of the Faculties of Education and Extension at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the Research Ethics Board at (780) 492-3751."

Appendix 'B'

Information about Research with Counselling Practicum Clients

Title: Self-Critical Experiences that Affect the Therapeutic Relationship

Principal Researcher: Gina Janzen
Department of Educational Psychology
1-135 Education North Building
Phone: 492-3746
Email: gjanzen@ualberta.ca

Clients you may be working with during the course of your counselling practicum may be invited to participate in a research study that is intended to explore the relationships people have with their therapists. Relationships – including relationships between clients and their therapists – are affected by many different things. A few factors that can influence how we relate to others are the internal standards we have for ourselves, the kinds of internal dialogues we have with ourselves as we interact with others, and the ways in which we evaluate ourselves – our thoughts, abilities and actions. People who have high internal standards and who may be very critical in their evaluations of themselves often have difficulties in their relationships with others, including with their therapist. At times, it interferes with them being able to benefit fully from their participation in counselling.

The purpose of this research is to explore and discuss the kinds of internal standards, evaluations and internal dialogues people have and how those things may be affecting the relationship between the client and the therapist. The hope is that having these discussions will help identify some thoughts, feelings, experiences or interactions that occur in therapy that may be keeping it from being as effective and helpful as it could be. It is also hoped that some of the thoughts, feelings, experiences or interactions that occur in therapy that make it more effective may also be identified through this process.

This research will be conducted by me; Gina Janzen, under the supervision of Dr. Bill Whelton, a professor of counselling psychology at the University of Alberta, Department of Educational Psychology. I (Gina) am currently a graduate student in the Counselling Psychology program at the University of Alberta. I am in the process of completing my Ph.D. in Counselling. This research will be conducted in partial fulfillment of the requirements for that program. While the identity of participants will be confidential and anonymous, the research findings may be presented at conferences, used for teaching purposes and/or published in professional journals.

Clients who have been identified (during the intake process, as noted by their scores on the Self-Criticism scale of the DEQ) as being very self-critical will be invited to participate in this research. They will be asked to attend three to four (3-4) meetings with Gina Janzen, the researcher. At the first meeting, we will review the research and I will attempt to answer any questions the client may have regarding me, the research, and/or the

process(es) that he/she will be involved in. The second and possibly third meetings we will have will be to conduct an in-depth interview regarding some of the client's experiences during therapy here at the Education Clinic. If possible, this will include reviewing a segment of videotape of one of the sessions the client will have had with you, the student therapist.

The interviews, resulting transcriptions and analyses will be kept anonymous – neither client nor student clinician will be identified. The audio- and videotapes of the interviews will be kept in a locked filing cabinet in my home until the research is complete and they will be kept for a minimum of 5 years. When I discuss my research with my supervisor, Dr. Bill Whelton or members of my committee, I will use pseudonyms or numbers, so that the identity of both the client and the therapist (student) is not known. If you decline to have your clients possibly participate in this research, this information, too, will be kept confidential, so that neither Dr. Bill Whelton nor any of your other professors will be aware of exactly who chose to participate and who did not. There should be no opportunity for your participation/non-participation in this research to affect your grades in your counselling practicum course, your grades in any other course or your standing within the program. You may also withdraw your consent having once given it. However, it is requested that once having given your consent, you withdraw later only if you feel you have been/will be harmed by your continued participation in this research. I am also available throughout the school year if you have questions or concerns regarding this research. You can feel free to contact me at the Education Clinic (492-3746) or via email: gjanzen@ualberta.ca.

CONSENT TO PARTICIPATE IN RESEARCH

I, _____, am giving my consent to having clients that I work with during my counselling practicum course possibly be invited by Gina Janzen to participate in her research project. I am aware that the purpose of this research is to explore and discuss the kinds of internal standards and internal dialogues clients have and how those things may be affecting the relationship between client and therapist. Through the use of an interview format, my client(s) may be asked to describe his/her thoughts, feelings, interactions and experiences in as much detail as possible. I understand that the present research is being completed by Gina Janzen, for her doctoral dissertation, as part of the requirements for the Doctor of Philosophy Program in Counselling. I also understand that Gina Janzen is working under the supervision of Dr. William (Bill) Whelton of the Department of Educational Psychology at the University of Alberta.

I understand that I may be requested to provide a videotape of a particular session I have had with a client that may be relevant to the present research, and am consenting to do so. I understand that neither Gina's supervisor, Dr. Bill Whelton, nor any of my professors will have any knowledge of whether or not I have agreed to participate in this research. I further understand that all information about me and my client(s) will be kept confidential and will in no way be permitted to influence my grades or

academic opportunities in any way. I am aware that my identity and the identity of my clients will be kept confidential, known only to Gina Janzen. When she discusses any part of her research with her supervisor or any other member of her Dissertation Committee, she will disguise the identity of any client and/or therapist who may be involved. When transcribing the interview recordings, Gina will use a pseudonym for my name, my client's name(s) and for the name(s) of any other person(s) that my client(s) may mention. These pseudonyms will also be used in preparing the written report for the dissertation. Any details in the interview recording that might identify me or any other person(s) that I mention will also be changed during the transcription process. Gina Janzen will also be the only person with access to the tape recording(s) and the interview transcript, and these will be stored in a secure place. I also understand that the interview recordings will be erased after the transcription process has been completed. I agree to maintain the confidentiality of any of my clients that choose to participate in this research. I agree not to discuss any aspect of my client's participation in the research with anyone other than my supervisor, and then only as it pertains to their therapy and the maintenance of the therapeutic relationship. I also agree not to initiate any discussion with a client regarding her/his participation in this research.

I am also aware that the information obtained in the interview will be used by Gina Janzen for the purposes of this research and that the transcript of the interview conducted may be included as an appendix in her written report for the research. In addition to being analyzed for a Doctoral Dissertation, the results may be presented at conferences and/or published in professional journals, and possibly used for teaching purposes. In signing this form, I am giving my consent for the results to be used in this manner.

I understand if I have any questions or concerns, I may speak to Gina Janzen at (780-492-3746) or her supervisor, Dr. Bill Whelton at the University of Alberta (780-492-7979). If I wish to contact a person from the University not directly involved in this research, with any questions or concerns I have, I may contact Dr. Derek Truscott at 492-1161.

Signature of Student Clinician: _____

Dated at the city of Edmonton, in the province of Alberta, this _____ Day of _____, 20___.

"This study has been reviewed and approved by the Research Ethics Board of the Faculties of Education and Extension at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the Research Ethics Board at (780) 492-3751."

Appendix 'C'
Interview Questions

- Beginning of Interview (Most general and open-ended)
    - Throughout the interview, remember to ask if there are examples of what the participant is describing on the videotape of the session.
    - What has the experience of therapy been like for you?
    - What kinds of things in therapy have been helpful? What kinds of things in therapy have **not** felt like they were helpful? (Tasks)
    - What kinds of experiences show you that your therapist does/does not understand what you want to get from therapy? (Goals)
    - How would you describe your present relationship with your therapist? (Bond)
        - Have you felt understood and accepted by your therapist?
    - Was there a moment when you felt your relationship with your therapist was particularly strong? When it felt weaker or less positive?
- Middle of Interview (More specific – good & bad experiences, strong feelings, IPR)
    - Are there differences between your recalled experience of this moment in therapy and your experience of it now, watching it on videotape?
    - Have there been moments in therapy where you experienced a significant shift in your relationship with your therapist? Can you describe what was happening then?
    - (While reviewing a portion of videotape) What were your thoughts, feelings or intentions during this moment in your therapy session?
    - (Referring to a portion of video) What were you thinking about yourself when that happened?
        - Were you evaluating yourself or anyone else right then?

- (Referring to a portion of the videotape) Was this experience or your reaction to it similar to any others you have had?
- (Referring to a portion of the videotape) What in your past experiences helped you make sense of what transpired just now between your therapist and you?
- Perfectionists often really struggle with admitting any weakness or struggle because these things appear like failure to them. Is this somewhat true of you?
    - It must have been so hard to come to therapy? Have you sometimes struggled with opening up fully to the therapist?
- Are there things that seem terribly difficult to talk about with your therapist? Is it partly because to do so would seem too shameful? or leave you feeling like too much of a failure?
- Do you sometimes want to conceal some of your struggle or pain from the therapist? To put on a brave face for them?
- If you felt the relationship with the therapist was not going well, would you blame yourself? Would you feel the need to try to fix it? Would it feel like one more failure to you? Would you want to conceal it?
- What would it mean to you if the therapy relationship was not going well?
-

- <u>Last Part of Interview</u> (Most direct)
    - Do you sometimes feel misunderstood or disrespected by the therapist?
    - Are there times when the therapist annoys or irritates you?
    - Do you feel in control of the course of your therapy?
    - Have you ever felt humiliated or put down in therapy?
        - Have you had the experience of feeling that your faults and imperfections are being exposed or dragged out into the open by therapy?

        - Have you felt vulnerable and exposed as a result of something that happened in therapy? Describe your reaction(s) to that -> your thoughts, feelings, and behaviours that followed/resulted from that experience.
    - Have you ever felt that therapy was disappointing overall?
        - Was there a time when you thought therapy was great but then you changed your mind? Can you tell me more about that?
    - How often do you evaluate what you say and/or do in therapy? How does that affect you? How does that affect therapy?
    - Would you describe yourself as very self-critical?
        - Your scores on the DEQ suggest that you tend to be really hard on yourself or critical of yourself. Do you think that has had any effect on your therapy or your relationship with your therapist?
        - Have there ever been times when your tendency to have high personal standards or to critique or evaluate yourself affected your therapy?
        - Are there times when you feel your therapist might be criticizing or evaluating you? (Projection?)

Appendix 'D'

Sample DEQ Items

- I set my personal goals and standards as high as possible
- Without support from others who are close to me, I would be helpless
- Other people have high expectations of me
- I am very sensitive to others for signs of rejection
- I often think about the danger of losing someone who is close to me
- The way I feel about myself frequently varies: there are times when I feel extremely good about myself and other times when I see only the bad in me and feel like a total failure
- I worry a lot about offending or hurting someone who is close to me
- After a fight with a friend, I must make amends as soon as possible
- I am very satisfied with myself and my accomplishments
- Being alone doesn't bother me at all
- If I fail to live up to expectations, I feel unworthy
- People will accept me no matter how many mistakes I have made